CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PARTICIPATING AGENCY-DIRECTED PERSONAL/RESPITE CARE PROVIDER

A participating personal/respite care provider is an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and has a current, signed Participation Agreement with DMAS (see "Exhibits" section at the end of this chapter for a sample of this form). The duties and responsibilities of the provider are the same for both services. Each service requires a separate Participation Agreement and provider identification (ID) number. The term "personal/respite care" is used throughout this manual wherever procedures and policies are alike for both services. A provider may, however, choose to offer only one of the two services.

Personal/respite care providers provide services designed to prevent or reduce institutional care by providing eligible recipients with personal care aides who perform basic health-related services. This chapter sets forth the requirements for approval to participate as a Medicaid provider of personal/respite care as a part of the Elderly or Disabled with Consumer-Direction (EDCD) Waiver. The personal/respite care provider will be reimbursed according to the fee schedule outlined in Chapter V. Any provider contracting with Medicaid to provide these services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

PARTICIPATING RESPITE FACILITY PROVIDER

A participating respite facility provider is a Medicaid-enrolled nursing facility.

PARTICIPATING ADULT DAY HEALTH CARE (ADHC) PROVIDER

A participating Adult Day Health Care (ADHC) provider is a facility that is licensed by the Virginia Department of Social Services (DSS) as an Adult Day Care Center, meets the standards and requirements set forth by DMAS, and has a current, signed Participation Agreement with DMAS (see "Exhibits" section at the end of this chapter for a sample of this form).

ADHCs offer community-based day programs providing a variety of health, therapeutic, and social services designed to meet the specialized needs of elderly and physically disabled recipients who are at risk of being placed in a nursing facility. ADHC services enable recipients to remain in their communities and to function at the highest level possible by augmenting the social support system already available to the recipient, rather than replacing the support system with more expensive institutional care. The ADHC is reimbursed according to the fee schedule outlined in Chapter V. Any provider contracting with Medicaid to provide these services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

PARTICIPATING PERSONAL EMERGENCY RESPONSE SYSTEM (PERS) AND MEDICATION MONITORING PROVIDER

A participating Personal Emergency Response System (PERS) and Medication Monitoring provider is a certified home health or personal care agency, a Durable Medical Equipment (DME) provider, or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring. The PERS provider must meet the standards and requirements set forth by DMAS, and have a current, signed Participation Agreement with DMAS (see "Exhibits" section at the end of this chapter for a sample of this form.) All PERS providers must enroll as DME providers in order to provide this service to Medicaid recipients and to receive reimbursement from Medicaid. Enrollment as a DME provider does not obligate the PERS provider to provide any other DME services. The agency designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

PERS and Medication Monitoring services are designed to prevent or reduce inappropriate institutional care by providing eligible recipients with services that will allow them to live independently while having access to emergency services. This chapter specifies the requirements for approval to participate as a Medicaid provider of the PERS and Medication Monitoring services as a part of the EDCD Waiver. The provider will be reimbursed according to the fee schedule outlined in Chapter V. Any provider contracting with Medicaid to provide services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

PARTICIPATING SERVICE FACILITATION PROVIDER

A participating Consumer-Directed (CD) Service Facilitator (SF) is a facility, agency, person, partnership, corporation, or association that meets the standards and requirements set forth by DMAS and has a current, signed Participation Agreement with DMAS.

Service facilitation agencies provide supportive services designed to prevent or reduce inappropriate institutional care by offering assistance to eligible recipients for the hiring, training, supervising, and firing responsibilities of the personal care aides, who perform basic health-related services. This chapter specifies the requirements for approval to participate as a Medicaid provider of service facilitation services. The service facilitation provider will be reimbursed according to the fee schedule outlined in Chapter V. Any provider contracting with Medicaid to provide services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid program prior to billing for any services provided to Medicaid clients. A copy of the Provider Agreement can be found in this chapter. All providers must sign the appropriate Participation Agreement and return it to the Provider Enrollment/Certification Unit. An original signature of the individual provider is required.

Upon receipt of the above information, a seven-digit Medicaid identification number is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.

A copy of the Provider Agreement, with instructions on how to complete the forms, can be found at the DMAS website, www.dmas.virginia.gov, or by contacting the Provider Enrollment/ Certification Unit toll-free at 1-888-829-5373. All providers must sign, complete the entire application, and submit it to the Provider Enrollment/Certification Unit. An original signature of the individual provider is required. The Medicaid Participation Agreement may be time-limited depending on the licensing required. All participating Medicaid providers are required to complete a new application and agreement with the Provider Enrollment/Certification Unit as a result of any name change or change of ownership.

Providers may request Participation Agreements by writing, calling, or faxing a request to:

First Health
VMAP-PEU
P.O. Box 26803
Richmond, VA 23261-6803

Phone: 1-804-270-5105 or 1-888-829-5373 (toll-free, in-state only)
Fax: 1-804-270-7027

AREAS OF SERVICE

The provider applicant notes on the application what localities (cities and counties) the provider wishes to serve. The provider must be able to adequately staff and supervise staff in any locality served by the provider's office. The provider may maintain separate provider agencies.

The provider should submit a provider application for each separate office which, upon approval, will be issued a separate provider identification number and will be expected to maintain all files related to individuals served by the office and to bill for those individuals from the office.

A differential rate is established for providers that are providing services to individuals residing in the Northern Virginia localities (defined in Chapter VI) to reflect the higher cost of operating in these localities (both higher capital and wage costs).

PROVIDER MAILINGS

Providers may choose to have their payments sent to one location and their other mailings, such as memorandums or letters, sent to another location within their organization. Please visit the DMAS website or contact the First Health – Provider Enrollment Unit (FH-PEU) if this is an option you would like to explore.

PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. Currently, dissemination of this information is accomplished through the DMAS website as well as, with regard to certain publications, by mailing such publications directly to providers, keyed to the provider number on the enrollment file. For publications that are mailed to providers, this means that each assigned provider receives program information. Since DMAS does not always know which provider groups have multiple offices or which groups use one central office, providers may receive multiple copies of such publications sent to the same location. Individual providers may request that publications not be mailed to them by completing a Mailing Suspension Request form and returning it to the First Health - Provider Enrollment Unit at the address given on the form. The Mailing Suspension Request form must be completed and signed by each provider within the group who is requesting that program information not be sent. The address is:

First Health
VMAP-PEU
P.O. Box 26803
Richmond, Virginia 23261-6803

Phone: 1-804-270-5105 or 1-888-829-5373 (toll-free, in-state only)
Fax: 1-804-270-7027

To resume the mailings, a written request must be sent to the address above.

(See the "Exhibits" section at the end of the chapter for a sample of the form.)

Copies of manuals, manual updates, and certain other publications are available on the DMAS website (www.dmas.virginia.gov). If you do not have access to the Internet, please contact DMAS' mailing contractor, Commonwealth Martin, at 804-780-0076.

PARTICIPATION REQUIREMENTS

All providers enrolled in the Virginia Medicaid program must adhere to the conditions of participation outlined in their Participation Agreements and must perform the following activities as well as any other specified by DMAS:

- Immediately notify DMAS and the First Health - Provider Enrollment Unit (FH-PEU), in writing, of any change in the information that the provider previously submitted to DMAS or FH-PEU. This includes any change in provider status (location, mailing and payment address, etc);

- Assure freedom of choice to recipients seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the service(s) required and included in the recipient's Plan of Care and participating in the Medicaid program at the time the service or services were performed;
- Assure the recipient's freedom to reject medical care and treatment;

- Accept referrals for services only when staff is available to initiate and perform the services on an ongoing basis;

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin;

- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which states that no otherwise qualified recipient with a disability shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Rehabilitation Act of 1973, as amended, requires reasonable accommodations for certain persons with disabilities;

- Provide services and supplies to recipients in full compliance with Title II of the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.), as amended, which provides civil rights protections to persons with disabilities with respect to employment, public accommodations, state and local government services, and telecommunications;

- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public;

- Submit charges to DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;

- Not require, as a precondition for admission or continued stay, any period of private pay or a deposit from the patient or any other party;

- Accept Medicaid payment from the first day of eligibility;

- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR, Section 447.15, provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered;

  Example: If a third party payer reimburses $5 out of an $8 charge and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made;

- Providers cannot bill recipients or DMAS for broken or missed appointments;

- Accept assignment of Medicare benefits for eligible Medicaid recipients;

- Use program-designated billing forms for submission of charges;
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Such records shall be maintained in a designated business office from which all provider business is conducted;
- Such records must be retained for a period of not less than five years from the last date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. Records of minors must be kept for at least five (5) years after such minor has reached the age of 18 years;
- Policies regarding the retention of records shall apply even if the provider discontinues operation. DMAS must be notified in writing of the storage, location, and procedures for obtaining records for review should the need arise. The location, agent, or trustee should be within the Commonwealth of Virginia;
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid recipients;
- When ownership of the provider agency changes, DMAS shall be notified at least 15 calendar days before the date of the change;
- Hold confidential and use only for authorized DMAS purposes all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public;
- Employ and supervise professionally trained staff meeting the requirements stated in this chapter; and
- Assure that no processing of bankruptcy or financial insolvency has been adjudicated or is pending in any state or federal court and agree to inform DMAS of any action instituted with respect to financial solvency.

BUSINESS OFFICE

The provider must operate from a business office, which is staffed and provides accessible staff space, files, business telephones for the recipient to contact the provider when necessary, and an address for receipt of mail and forms.

RECIPIENT CHOICE OF PROVIDER

If services are authorized and there is more than one approved provider in the community, the recipient will have the option of selecting the provider of his or her choice.

At the time individuals are approved for services, the Pre-Admission Screening (PAS) Team must inform the individual of available service providers and (1) that they have the option of selecting their providers and (2) provide a list of service providers from which to choose.

ADVANCE DIRECTIVES

At the time of their admission to services, all providers participating in the Medicare and Medicaid programs must provide adult recipients with written information regarding each individual's right to make medical care decisions as outlined in this section. This includes the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and relating to the provision of such care when the recipient is incapacitated. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive. Further, the law does not require recipients to execute an advance directive.

Under the law, providers must:

- Provide all adult recipients with written information about their rights under state law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives, as well as the provider's written policies respecting the implementation of such rights;
- Inform recipients about the provider's policy on implementing advance directives;
- Document in the recipient's medical record whether he or she has signed an advance directive;
- Not discriminate against a recipient based on whether he or she has executed an advance directive; and
- Provide staff and community education on advance directives.

PROVIDER PARTICIPATION STANDARDS FOR PERSONAL/RESPITE CARE SERVICES

In addition to the above, to be enrolled as a Medicaid personal/respite care provider and maintain provider status, an agency must meet the following special participation conditions:

Staffing Requirements

1. Registered Nurse (RN)

   The provider must employ (or subcontract) and directly supervise a registered nurse (RN) who will provide ongoing supervision of all personal care aides. The RN must be currently licensed to practice in the Commonwealth of Virginia and have at least two (2) years of related clinical experience as a RN or a licensed practical nurse (LPN). Clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or nursing facility. The RN must have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children, recorded in the nurse's personnel file. Also, the provider must comply with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. Documentation of license, clinical experience, work references, and criminal record checks must be maintained in the RN's personnel file for review by DMAS staff.

2. Personal Care Aide

   Each personal care aide hired by the provider must be evaluated by the provider to ensure compliance with qualifications as required by DMAS. Basic qualifications for personal care aides include:

   - Physical ability to do the work;
   - Ability to read and write in English to the degree necessary to perform the expected tasks;
   - Completion of DMAS-approved nurse aide training program. A list of approved schools and programs are located on the DMAS website at www.dmas.virginia.gov. Prior to assigning an aide to a recipient, the provider must obtain documentation that the aide has satisfactorily completed a training program consistent with DMAS requirements. If the aide training program/school is not listed on the approved list, the provider can submit a copy of the aide certificate and the school's curriculum to the Waiver Services Unit (WSU) at DMAS for verification of the aide's qualifications to provide Medicaid services under the EDCD Waiver. (See "Exhibits" section at the end of this chapter for the Aide Training Course Outline.);

DMAS requirements may be met in one of three ways:

a. Registration as a Certified Nurse Aide: The Virginia Board of Nursing maintains a registry for Certified Nurse Aides. Each aide who is registered with the Board of Nursing will have a certificate of registration containing a registration number and an expiration date. Any aide who has such a certificate meets the DMAS standard for participation as a personal care aide. A copy of the state certificate must be maintained in the aide's personnel record. If the certification has expired and the aide has not renewed the certification, the agency must contact the Board of Nursing to ensure that the aide's certification was not revoked for disciplinary reasons and that the aide meets one of the other two DMAS requirements. DMAS does not require a Board of Nursing Nurse Aide Certification to perform personal/respite care services; it is merely one type of certification that meets DMAS requirements.

b. Graduation from an Approved Educational Curriculum: The Board of Nursing has an approved list of educational curricula offered by educational institutions throughout the Commonwealth of Virginia which offer certificates qualifying the student as a Nursing Assistant, Geriatric Assistant, or Home Health Aide. If an aide has successfully completed one of these Board of Nursing-approved courses, the provider must obtain a copy of the applicant's certificate, ensure that it is from a Board of Nursing- accredited institution, and maintain this documentation in the aide's personnel file for review by DMAS staff.

   Numerous hospitals, nursing facilities, and educational institutions also provide nursing assistant training that is not Board of Nursing-approved (e.g., out-of-state curricula). To ensure that the training content for a Nursing Assistant Program not approved by the Board of Nursing meets the minimum acceptable requirements, the agency must contact the DMAS Waiver Services Unit to determine whether the curriculum has previously been approved by DMAS. If the curriculum was not previously approved by DMAS, the provider must obtain the curriculum and submit it to DMAS for approval prior to offering employment for Medicaid-reimbursed cases.

c. Provider-Offered Training: In lieu of participating in a course offered at an educational institution, a provider may develop and offer its own training program or use the DMAS Personal Care Aide Training Curriculum, which is found in the "Exhibits" section at the end of this chapter. The content of the training must be consistent with the DMAS Personal Care Aide Training curriculum. The curriculum must be approved by DMAS prior to offering this training.

Regardless of the method of training received, documentation must be present indicating the training has been received prior to assigning an aide to a recipient. Based on continuing evaluations of the aide's performance and the recipient's individual needs, the RN Supervisor shall identify any significant gaps in the

aide's ability to function competently and shall provide the necessary training.

The provider should verify all information on the employment application prior to hiring a personal care aide. The aide must have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. If possible, obtain references from the educational facility, vocational school, or institution where the aide's training was received. Documentation of the date of the reference check, the individual contacted and his or her relationship to the aide (friend, co-worker, supervisor), and the content of the reference check must be maintained in the employee's personnel record. These qualifications must be documented and maintained in the provider personnel files for review by DMAS staff. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files. In addition, the provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia.

- A personal care aide cannot be the parents/stepparents of minor children or spouses of recipients receiving waiver services. Payment may be made for services rendered by other family members only when there is written objective documentation as to why there are no other aides or providers available to provide care for the recipient. For agency-directed services, the family member providing care to the recipient must be employed by the personal care provider and must meet the same requirements as other aides.

It is extremely important that the minimum qualifications be met by each personal care aide to ensure the health, safety, and welfare of each recipient enrolled in the EDCD Waiver.

3. Licensed Practical Nurse (LPN)

Through the respite care program, the provider may be reimbursed for the services of a LPN currently licensed to practice in the Commonwealth of Virginia as long as the service is ordered by a physician and the provider can document the recipient's skilled needs. DMAS will reimburse for LPN respite care for those recipients who require the skilled level of care and who meet the criteria below.

The circumstances that warrant provision of respite care by a LPN are:

- The recipient receiving care has a need for routine skilled care that cannot be provided by unlicensed personnel (i.e., recipient on a ventilator, recipient requiring nasogastric or gastrostomy feedings, etc.);

- No other individual in the recipient's support system is able to provide the skilled component of the individual's care during the caregiver's absence;
- The recipient is unable to receive skilled nursing visits from any other source

which could provide the skilled care usually given by the caregiver; and

- A physician's order for services is obtained prior to the service begin date and updated every six months.

The provider must verify a satisfactory work record of the LPN providing respite care through at least two (2) references obtained from prior employment, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files. If possible, obtain references from the educational facility, vocational school, or institution where the LPN received training. Documentation of the date of the reference check, the individual contacted and their relationship to the LPN (friend, co-worker, supervisor), and the content of the reference must be maintained in the employee's record. The provider shall not hire any persons who have been convicted of barrier crimes in § 32.1-162.9:1 of the Code of Virginia.

Documentation of all staff credentials must be maintained in the provider's personnel files for review by DMAS staff.

Change of Ownership

When ownership of the provider changes, DMAS and FHS-PEU must be notified within 15 calendar days from the effective date of the change. A new Participation Agreement with a notice of organizational structure, statements of financial solvency and service comparability, and full disclosure of all information required by this chapter relating to ownership and interest will be required.

In addition to the above, all providers enrolled in the Virginia Medicaid program must adhere to the conditions outlined in their individual Participation Agreements.

PROVIDER PARTICIPATION STANDARDS FOR ADULT DAY HEALTH CARE (ADHC) SERVICES

Licensing Requirement

To be enrolled as a Medicaid Adult Day Health Care (ADHC) provider, the ADHC Center must be an Adult Day Care Center licensed by the Virginia Department of Social Services (DSS). A copy of the current license must be available to FHS-PEU for verification purposes prior to enrollment as a Medicaid provider. DMAS will notify DSS when an ADHC agreement is issued to a licensed center. DSS will notify DMAS whenever a change to the ADHC's status as a licensed Adult Day Care Center is made by DSS.

Each ADHC Center participating with Medicaid is responsible for adhering to the DSS Adult Day Care Center standards. The DMAS special participation conditions included here are standards imposed in addition to DSS standards, which must be met to perform Medicaid ADHC services.

Physical Plant Requirements

The ADHC must be able to provide a separate room or area, equipped with one bed or cot for every twelve Medicaid recipients. This bed or cot must be available for anyone who becomes ill, needs to rest, or needs to have privacy.

Staff Requirements

The number of staff required for an ADHC Center depends upon the level of care required by its participants. Each ADHC Center is required to employ sufficient interdisciplinary staff to adequately meet the health, maintenance, and safety needs of each recipient. The following staffing guidelines are required by DMAS. However, DMAS reserves the right to require an ADHC Center to employ additional staff, if, on review, DMAS staff find evidence of unmet recipient needs.

"Staff" is defined as professional and aide staff.

"Professional staff" is defined as the Director, Activities Director, RN, Therapist, or Social Worker.

Adult Day Health Care (ADHC) Minimum Staffing Requirements

1. The ADHC Center will always maintain a minimum staff-recipient ratio of one staff member to every six recipients (Medicaid and other participants).

2. There shall be at least two (2) staff persons at the ADHC Center at all times when there are Medicaid recipients in attendance.

3. In the absence of the Director, a professional staff member shall be designated to supervise the program.

4. Volunteers shall be included in the staff-recipient ratio only when they meet the qualifications and training requirements of paid staff, and, for each volunteer, there shall be at least one paid employee also included in the staff-recipient ratio.

5. Any ADHC Center that is co-located with another facility shall count only its own separate identifiable staff in the Center's staff-recipient ratio.

6. The ADHC Center must employ staff sufficient to meet the needs of the recipients. These staff are the:

    - Director - responsible for the overall management of the ADHC Center's programs. This individual is the provider contact person for THE PRE-AUTHORIZATION CONTRACTOR and is responsible for participation agreements and receiving and responding to communication from DMAS. The Director is responsible for ensuring the initial development of the Plan of Care (DMAS-301) for ADHC recipients;

- Activities Director - responsible for directing recreational and social activities for the ADHC recipients;

- Program Aides - responsible for overall assistance with care and maintenance of the recipient (assistance with activities of daily living, recreational activities, and other health and therapeutic related activities); and

- Registered Nurse (RN) - responsible for administering and monitoring the health needs of the ADHC recipients. The RN is responsible for the planning, organization, and management of a Plan of Care involving multiple services where specialized health care knowledge must be applied in order to attain the desired result. The RN must be present a minimum of 8 hours each month at the ADHC Center. The nurse must be available to meet the nursing needs of all Medicaid ADHC recipients. DMAS does not require that the nurse be a full-time staff position, but the nurse's schedule must be arranged so that each recipient is seen every month. There must be a RN available, by telephone at a minimum, to the ADHC Center's recipients during all times the ADHC Center is in operation. The ADHC Center may contract with either an individual or agency to provide these services, but the ADHC Center must ensure quality service delivery and coordination of the Plan of Care.

  The ADHC Center may use one person to fill more than one professional position as long as the requirements for both positions and other staffing requirements are met. The ADHC Center may employ staff as either full-time or part-time as long as the person hired can fulfill the duties of the position and meet the needs of the recipients. DMAS will enter into Participation Agreements only with ADHC Centers employing a sufficient number of staff whose employment status (full-time, part-time, or contracted RN services) is determined to be sufficient based on the number of recipients in the ADHC Center and the overall functional level or specialized needs of those recipients.

7. The Director will assign a professional staff member to act as ADHC Coordinator for each recipient. The identity of the ADHC Coordinator must be documented in the recipient's file. The ADHC Coordinator is responsible for management of the recipient's Plan of Care and review of the recipient's Plan of Care with the program aides. In cases where the recipient only receives ADHC and PERS, the ADHC Coordinator is responsible for ensuring the continued appropriateness of PERS.

It is the ADHC Coordinator's responsibility to inform the program aides of changes in the Plan of Care and give instruction and direct supervision in any new tasks. If the recipient's Plan of Care requires a particular task a program aide is not familiar with, any professional staff available is expected to provide the aide with instruction and direct supervision in the task.

Each professional staff member is responsible for providing input to the Plan of Care, sharing expertise with other staff members through in-services, providing direct supervision to aides or providing direct care to the recipients, or both.

A multi-disciplinary approach to problem identification, recipient goal setting, development and implementation of the Plan of Care, and supervision of nonprofessional staff is essential to ensure the provision of quality ADHC services. However, the Center Director has the ultimate responsibility for directing the ADHC Center program and supervision of its staff.

Minimum Qualifications of Adult Day Health Care Staff

I. Program Aide

Each program aide hired by the provider must be evaluated by the provider to ensure compliance with minimum qualifications as required by DMAS. Basic qualifications for ADHC program aides include:

- Ability to read and write in English to the degree necessary to perform the expected tasks;
- Physically able to do the work; and
- Special training in the needs of the elderly and individuals with disabilities through the completion of a minimum 40-hour training program consistent with DMAS requirements. The provider must obtain documentation that the aide has satisfactorily completed a training program consistent with DMAS requirements. (See "Exhibits" section at the end of this chapter for the ADHC Program Aide Training Outline.) DMAS requirements may be met in one of five ways:

1. Registration as a Certified Nurse Aide: The Virginia Board of Nursing maintains a registry for Certified Nurse Aides. Each aide who is registered with the Board of Nursing will have a certificate of registration, which contains a registration number and an expiration date. Any aide who has such a certificate meets the DMAS standard for participation as an ADHC Aide. A copy of the state certification must be maintained in the aide's personnel record. If the certification has expired and the aide has not renewed the certification, the provider must contact the Board of Nursing to ensure that the aide's certification was not revoked for disciplinary reasons. DMAS does not require Board of Nursing Nurse Aide Certification in order to perform ADHC aide services; it is merely one type of certification that meets DMAS requirements.

2. Graduation from an Approved Educational Curriculum: The Board of Nursing has an approved list of educational curricula offered by educational institutions throughout the Commonwealth of Virginia which award certificates qualifying the graduate as a Nursing Assistant, Geriatric Assistant, or Home Health Aide. If an aide has successfully completed one of the Board of Nursing-approved courses, the provider must obtain a copy of the applicant's certificate, verify that it is from a Board of Nursing-accredited institution, and maintain the documentation in the aide's personnel file for review by DMAS staff.

Nursing Assistant training is also provided by numerous hospitals, nursing facilities, and educational institutions, which are not approved by the Board of Nursing (e.g., out-of-state curricula). To ensure that the training content for a Nursing Assistant Program not approved by the Board of Nursing meets the minimum acceptable requirements, the agency must contact the DMAS Waiver Services Unit at 804-786-1465 to determine whether the curriculum has previously been approved by DMAS. If the curriculum was not previously approved by DMAS, the provider must obtain the curriculum and submit it to DMAS for approval prior to offering employment for Medicaid reimbursed cases.

3. Provider-Offered Training: In lieu of participation in a course offered at an educational institution, a provider may develop and offer his or her own training program. The content of the training must be consistent with the Adult Day Health Care Program Aide Training Outline found in the "Exhibits" section at the end of this chapter, must be a minimum of 40 hours, and must be approved by DMAS.

4. Completion of the VADSA (Virginia Adult Day Services Association) Aide Training program is acceptable. This program has been previously reviewed and approved by DMAS. Note: an aide who has completed the VADSA training does not meet the qualifications as an aide for in-home personal/respite care services.

5. Completion of the most current National Adult Day Services Association curriculum. (Information for this curriculum can be accessed by mailing a request in writing to the address below or by checking their website at www.ncoa.org):

   The National Adult Day Health Services Association
   409 Third Street, SW
   Suite 200
   Washington, DC 20024

   Note: An aide who has completed this training does not meet the qualifications as an aide for in-home personal/respite care services.

The aide must have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files. If possible, obtain references from the educational facility, vocational school, or institution where the aide's training was received. Documentation of the date of the reference check, the individual contacted and his or her relationship to the aide (friend, co-worker, supervisor), and the content of the reference check must be maintained in the employee's personnel record. These qualifications must be documented and

maintained in the provider personnel files for review by DMAS staff. In addition, the provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia.

Regardless of the method of training received, documentation must be present indicating the training has been received prior to assigning an aide to ADHC recipients. The provider must verify all information on the employment application prior to hiring an ADHC program aide. It is important that the minimum qualifications be met by each hired aide to ensure the health and safety of recipients.

II. Registered Nurse (RN)

The RN must:

A. Be registered and currently licensed to practice nursing in the Commonwealth of Virginia;

B. Have two years of related clinical experience as an RN. Clinical experience may include work in an acute care hospital, rehabilitation hospital, public health clinic, home health agency, or nursing facility; and

C. The RN must have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children, recorded in the nurse's personnel file. Also, the provider must comply with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. Documentation of both license and clinical experience must be maintained in the provider's personnel file for review by DMAS staff. A copy of the RN's current license must be in the personnel record.

III. Activity Director

The Activity Director must:

A. Have a minimum of 48 semester hours or 72 quarter hours of post-secondary education from an accredited college or university with a degree in recreational therapy, occupational therapy, or a related field such as art, music, or physical education;

B. Have one year of related experience, which may include work in an acute care hospital, rehabilitation hospital, nursing home, or have completed a course of study including the prescribed internship in occupational, physical, and recreational therapy or music, dance, art therapy, or physical education; and

C. Have a satisfactory work record as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record

checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files.

IV. Director

The Director must meet the qualifications of the Director as specified in the DSS standards for Adult Day Care Centers.

Documentation of all staff credentials must be maintained in the provider's personnel files for review by DMAS staff.

PROVIDER PARTICIPATION STANDARDS FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) AND MEDICATION MONITORING SYSTEMS

In addition to meeting the general conditions and requirements for home- and community-based care participating providers, PERS providers, which provide PERS and Medication Monitoring, must also meet the qualifications described below.

To be enrolled as a provider of PERS, a provider must be a certified home health or personal care agency, a Durable Medical Equipment (DME) provider, a hospital, or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring. All PERS providers must enroll as a DME provider in order to provide this service to Medicaid recipients and to receive reimbursement from Medicaid. Enrollment as a DME provider does not obligate the PERS provider to provide any other DME services.

The PERS provider must provide an emergency response center staff with fully trained operators who are capable of receiving signals for help from a recipient's PERS equipment 24 hours a day, 365, or 366 as appropriate, days per year; determining whether an emergency exists; and notifying an emergency response organization or an emergency responder that the PERS recipient needs emergency help.

The PERS provider must comply with all applicable Virginia statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the services to be performed.

The PERS provider has the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required, to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the recipient's notification of a malfunction of the console unit or activating devices, while the original equipment is being repaired.

The PERS provider must properly install all PERS equipment into a PERS recipient's functioning telephone line and must furnish all supplies necessary to ensure that the system is installed and working properly.

The PERS installation includes local seize line circuitry, which guarantees that the unit will have priority over the telephone connected to the console unit should the telephone be off the hook or in use when the unit is activated.

The PERS provider must maintain all installed PERS equipment in proper working order.

The PERS provider must maintain a data record for each PERS recipient at no additional cost to DMAS. The record must document all of the following: delivery date and installation date of the PERS; enrollee/caregiver signature verifying receipt of the PERS device; verification by a test that the PERS device is operational, monthly or more frequently as needed; updated and current recipient responder and contact information, as provided by the recipient or the recipient's care provider; and a case log documenting recipient system utilization and recipient or responder contacts and communications.

The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) Safety Standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL Safety Standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the recipient.

The PERS provider must furnish education, data, and ongoing assistance to DMAS to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and must instruct the recipient, caregiver, and responders in the use of the PERS service.

The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by persons who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the recipient's home for a minimum period of 24 hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the recipient resetting the system in the event it cannot get its signal accepted at the response center.

Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to ensure that the monitoring agency and the agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from the recipient's PERS equipment. The monitoring agency's equipment must include the following: a primary receiver and a back-up receiver, which must be independent and interchangeable; a back-up information retrieval system; a clock printer, which must print out the time and date of the emergency signal, the PERS recipient's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test; a back-up power supply; a separate telephone service; a toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and a telephone-line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

The monitoring agency must maintain detailed technical and operation manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures.

The PERS provider shall document and furnish a written report for each emergency signal that results in action being taken on behalf of the recipient. This excludes test signals or activations made in error. This written report shall be furnished to the personal care provider or, in cases where the recipient only receives ADHC services, to the ADHC provider.

The PERS provider is prohibited from performing all types of direct marketing activities to Medicaid recipients. "Direct marketing" means directly or indirectly conducting door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; mailing directly; paying "finder's fees"; offering financial incentives, rewards, gifts, or special opportunities to eligible recipients as inducements to use their services; continuous, periodic marketing activities to the same prospective recipient (e.g., monthly, quarterly, or annual give-aways) as inducements to use their services; or engaging in marketing activities that offer potential customer rebates or discounts in conjunction with the use of their services or other benefits as a means of influencing recipients' use of providers' services.

In addition to the above, all PERS providers enrolled in the Virginia Medicaid program must adhere to the conditions outlined in their individual Participation Agreements.

PROVIDER PARTICIPATION STANDARDS FOR CONSUMER-DIRECTED (CD) SERVICES

In addition to meeting the general conditions and requirements for home- and community-based care participating providers, CD service providers must meet the following special participation conditions:

1. CD Service Facilitator Requirements

   The CD Service Facilitator provides ongoing supervision of the individual's Plan of Care. It is preferred that the CD Service Facilitator possess a minimum of an undergraduate degree in a human services field or be a RN currently licensed to practice in the Commonwealth of Virginia. In addition, the CD Service Facilitator must have two years of satisfactory experience in the human services field working with persons with severe disabilities or the elderly. The CD Service Facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the application form, found in supporting documentation, or observed during the interview. Observations during the interview

must be documented. The knowledge, skills, and abilities shall include, but are not necessarily limited to:

a. Knowledge of:

(1) Types of functional limitations and health problems that are common to different disability types and the aging process, as well as strategies to reduce limitations and health problems;

(2) Physical assistance typically required by people with severe physical disabilities or elderly persons, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(3) Equipment and environmental modifications that are commonly used and required by people with physical disabilities or elderly persons, which reduce the need for human help and improve safety;

(4) Various long-term care program requirements, including nursing home and assisted living facility placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance and respite services;

(5) DMAS consumer-directed personal care aide and respite services program requirements, as well as the administrative duties for which the individual will be responsible;

(6) Conducting assessments (including environmental, psychosocial, and functional factors) and their uses in care planning;

(7) Interviewing techniques;

(8) The recipient's right to make decisions about, direct the provisions of, and control his or her services, including hiring, training, managing, approving time sheets, and firing a personal care aide;

(9) The principles of human behavior and interpersonal relationships; and

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with individuals and service providers;

(2) Observing, recording, and reporting behaviors;

(3) Identifying, developing, and providing services to persons with severe disabilities or elderly persons; and

(4) Identifying services within the established services system to meet the recipient's needs.

c. Ability to:

(1) Report findings of the assessment or onsite visit, either in writing or in an alternative format for persons who have print impairments;

(2) Demonstrate a positive regard for individuals and their families;

(3) Be persistent and remain objective;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively both orally and in writing; and

(6) Develop a rapport and communicate with different types of persons from diverse cultural backgrounds.

Documentation of a degree or license and previous satisfactory experience must be maintained in the provider's personnel file for review by DMAS staff. There must also be documentation of positive work history as evidenced by at least two satisfactory reference checks recorded in the CD Service Facilitator's personnel file.

If the CD Service Facilitator is not a RN, the CD services facilitator must inform the individual's primary health care provider that services are being provided and request consultation as needed. A lapse in qualified CD Service Facilitator availability may require that the CD Service Facilitator subcontract with another provider until appropriate staff can be hired. If the provider is unable to provide service facilitation services for a period of 30 days, the CD Service Facilitator should transfer recipients to another CD Service Facilitator and immediately notify the pre-authorization contractor.

The inability to obtain and retain personal care aides can be a serious threat to the safety and health of a recipient. If a recipient is consistently (over a 30-day period)

unable to hire and retain the employment of a personal care aide, the CD Service Facilitator should discuss transferring the recipient to agency-directed (AD) services.

2. Consumer-Directed (CD) Personal Care Aide Requirements

It is the recipient's responsibility to hire, train, supervise, and, if necessary, fire the personal care aide. Each personal care aide hired by the recipient must be evaluated by the recipient to ensure compliance with the minimum qualifications as required by DMAS. Basic qualifications for personal care aides include:

- Being 18 years of age or older;
- Being able to read and write in English to the degree necessary to perform the tasks expected;
- Possessing basic math, reading, and writing skills;
- Having the required skills to perform care as specified in the individual's Plan of Care;
- Possessing a valid Social Security Number;
- Submitting to a criminal history record check and a child protective services central registry check for care aides that care for minor children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files. The personal care aide will not be compensated for services provided to the individual once the records check verifies the personal care aide has been convicted of any of the crimes that are described in 12 VAC 30-90-180;
- Willingness to attend or receive training at the recipient's request;
- Understanding and agreeing to comply with the consumer-directed personal/respite services program requirements;
- Receive periodic tuberculosis (TB) screening;
- Personal care aides may be members of the recipient's family, with the exception of parents or stepparents of a minor (under 18 years of age), or a recipient's spouse. In addition, anyone who has legal guardianship for the recipient shall also be prohibited from being a personal care aide under this program. A non-family live-in personal care aide may be the provider of Medicaid-funded consumer-directed personal/respite services for any competent recipient; and
- Personal care aides who are providing direct care to recipients are prohibited from also directing that recipient's consumer-directed services.

The recipient should verify information on the application form prior to hiring a personal care aide. It is important that the minimum qualifications be met by each personal care aide hired to ensure the health and safety of recipients. These qualifications must be documented by the recipient and maintained by the CD Service Facilitator for review by DMAS staff.

CD Service Facilitators are not responsible for finding personal care aides for the recipient. CD Service Facilitators are also not responsible for verifying personal care aides' qualifications. This is the recipient's responsibility.

UTILIZATION REVIEW (UR)

Utilization Review (UR) is conducted periodically. DMAS Utilization Review Analysts will review provider compliance with participation standards during Utilization Review. DMAS may retract funds based on documentation reviewed. (See Chapter VI for more information about Utilization Review.)

ANNUAL LEVEL-OF-CARE REVIEWS

DMAS will conduct annual level-of-care reviews of each recipient according to established procedures described in Chapter VI.

RECIPIENT RIGHTS/RESPONSIBILITIES

The provider must have a written statement of recipient rights, which clearly states the responsibilities of both the provider and the recipient in the provision of care. This statement of recipient rights must be signed by the recipient and the provider representative at the time services are initiated. This statement must be maintained in the recipient's file, and a copy must be given to the recipient. The statement of recipient rights must include the following:

- The provider's responsibility to notify the recipient in writing of any action taken which affects the recipient's services;
- The provider's responsibility to render services according to acceptable standards of care;
- The provider's procedures for patient pay collection;
- The recipient's obligation for patient pay, if applicable;
- The provider's responsibility to make a good faith effort to provide care according to the scheduled Plan of Care and to notify the recipient when unable to provide care;
- The provider must inform the recipient of his or her responsibility to have some planned back-up for times when the provider is unable to secure coverage and to identify which staff the recipient should contact regarding schedule changes;
- The provider's responsibility to treat the recipient with respect, to respond to any

questions or concerns about the care rendered, and to routinely check with the recipient about his or her satisfaction with the services being rendered;

- The recipient's responsibility to notify the appropriate provider staff whenever the recipient's schedule changes or assigned staff fail to appear for work; and
- The recipient's responsibility to treat provider staff with respect and to communicate problems immediately to the appropriate provider staff.

The Recipient's Rights/Responsibilities Statement must include the following notification of the appropriate resources for complaint resolution:

"The DMAS (Medicaid) pays (provider name) to provide (type of service) to you. If you have a problem with these services you should contact (RN, Service Facilitator, ADHC Coordinator, Provider Director, or PERS provider) at (provider telephone)."

If the staff at the agency is unable or unwilling to help you resolve the problem, you may contact the Waiver Services Unit at DMAS by calling 804-786-1465 or by mail at:

DMAS
Waiver Services Unit
600 East Broad Street
Suite 1300
Richmond, VA 23219

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provision for individuals with disabilities in the provider's program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. By signing the check, the provider indicates compliance with Section 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

TERMINATION OF PROVIDER PARTICIPATION

The Participation Agreement may be time-limited. It will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no billing within 36 months), or resignation by the provider. DMAS will request a copy of any renewed license or certification prior to its expiration.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and to the First Health Provider Enrollment Unit thirty (30) days prior to the effective date. The addresses are as follows:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

First Health VMAP Provider Enrollment Unit
P.O. Box 26803
Richmond, Virginia 23261

DMAS may terminate a provider from participating upon 30 days' written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to recipients after the date specified in the termination notice.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Subsection § 32.1-325 (c) of the Code of Virginia mandates that any Medicaid agreement or contract shall terminate upon conviction of the provider of a felony. A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse action, such as termination or suspension of the Provider Agreement or denial of payment for services rendered based on Utilization Review (UR) decisions.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration to the preliminary findings, an informal conference, and a formal evidentiary hearing. The provider will have 30 days from the date of receipt of the notice to submit information for written reconsideration and will have 30 days to request an informal conference and/or a formal evidentiary hearing once the reconsideration decision is rendered.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§ 2.2-4000 et seq. of the Code of Virginia) and the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action, which includes termination or suspension of the Provider Agreement and denial of payment for services rendered, based on Utilization Review (UR) decisions. State-operated provider means a provider of Medicaid services, which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a DMAS Director Review, and a Secretarial Review. First, the state-operated provider will submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, Notice of Proposed Action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought, and the reasons for seeking the adjustment. The Division Director will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable law and regulations. The Division Director will consider any recommendation of his/her designee and render a decision.

A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his/her designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources or any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries will be final.

EXHIBITS

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

http://www.dmas.virginia.gov

PERSONAL EMERGENCY RESPONSE SYSTEM

HOME AND COMMUNITY BASED CARE SERVICES

ENROLLMENT PACKAGE

Contents:

- Personal Emergency Response System Enrollment Request Letter
- Personal Emergency Response System Enrollment Instructions
- Personal Emergency Response System Enrollment Application
- Home and Community Based Care Services Personal Emergency Response System Participation Agreement
- Home and Community Based Care Application for Provider Status as a Personal Emergency Response System Provider
- Mailing Suspension Request - Signature Waiver - Pharmacy POS Form
- Medicare Crossover Form
- Electronic Funds Transfer Informational Letter
- Electronic Funds Transfer Application

First Health Services Corporation

Fiscal Agent for Virginia's Medical Assistance Program – Provider Enrollment Unit

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Thank you for your request to participate in the Commonwealth of Virginia's Medical Assistance Program. Requesting to become a provider does not constitute automatic acceptance into the Program. Upon receipt of your completed Enrollment Application, processing of the enrollment may take up to 15 business days. First Health is unable to accept altered agreements or agreements without a signature. Additionally, the application will be returned if any portion is filled out incorrectly and/or missing information.

Enclosed is the Virginia Department of Medical Assistance Services, Provider Enrollment Application. This application is required for initial enrollment in any of the Virginia Medical Assistance Programs including the enrollment of additional locations. Each practice location must be enrolled separately. A completed Enrollment Application must include the Enrollment Application, Address Form, Participation Agreement, and any required licensure documents. Personal Emergency Response System providers must submit a copy of either their current VA Board of Pharmacy Permit, VA Board of Pharmacy Medical Equipment Supply Permit, Business License, or documentation stating a Business License is not required in the area that they are rendering services. If the requested date of enrollment is more than one year in the past, supporting documentation and a claim for services rendered must be submitted with the completed Enrollment Application.

Out-of-State Enrollment in Virginia Medical Assistance Programs

Adult Day Health Care providers must be located within the Commonwealth of Virginia. Out-of-state providers are not eligible for this Virginia Medical Assistance Program.

First Health Services Corporation (FHSC), fiscal agent for Virginia's Medical Assistance Program, administers all provider enrollment functions for Virginia Medicaid. First Health's Provider Enrollment Unit is available during the hours of 8:00 A.M. and 5:00 P.M. EST, Monday through Friday, to answer any enrollment questions you may have.

You may contact a Provider Enrollment Representative by calling:

1-888-829-5373 (In-state Toll Free)
OR
804-270-5105

Electronic copies of all Virginia Medicaid enrollment forms can be found at the Virginia Department of Medical Assistance Services website at (www.dmas.virginia.gov). **All applicants should visit the Virginia Department of Medical Assistance Services website and review the Durable Medical Equipment & Supplies Manual for their specific provider participation requirements.** Completed Enrollment Applications should be mailed or faxed to First Health's Provider Enrollment Unit at the following address or fax number:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health Services Corporation

ENROLLMENT FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

1. Provider Program

The Virginia Medical Assistance Program(s) for which you are requesting enrollment. Note: Medallion II is the Virginia Medicaid Health Maintenance Organization (HMO) program.

2. Requested Effective Date of Enrollment

Enter the date that you are requesting your enrollment to begin.

3. Existing Virginia Medicaid Provider Numbers

If previously enrolled, list all Virginia Medicaid provider numbers assigned.

4. Legal Business Name.

The name of the business as registered with the Internal Revenue Service. This name is used to generate and report 1099 information each year. A provider doing business under his/her own name should leave this section blank.

Individual Provider Name.

Individual providers are enrolled under the last name, first name, middle initial and professional title (e.g., M.D.). This name is used to generate claim payments and report 1099 information.

5. License/Certification Number

The license number stated on your medical license from the **Virginia Department of Health Professions**. **Out-of-state providers must attach a legible copy of their licensure to the completed Enrollment Application.** If you have multiple licenses to report, please attach a separate sheet.

6. Specialty Codes

The primary specialty is first. Enter the date you were certified for your specialty. If you are certified in more than two specialties attach an additional sheet indicating the specialty and the effective dates. If you are a physician and you have a specialty, but do not include it on your Medicaid application, you will not be reimbursed for services that require a specialty certification for payment.

7. FDA Mammography Certification.

Enter your FDA Mammography Certification number. Enter the original issuance and expiration dates. You must include a legible copy of your FDA Mammography Certification with this application.

8. UPIN Number.

Enter your six (6) digit Medicare Universal Provider Identifier Number or your UPIN on this line, if available. **Enter the unique UPIN for the enrolled provider and not the same number for each provider in a practice.**

9. DEA Number.

Enter your Drug Enforcement Agency number. If applicable, attach a legible copy of your DEA license to the Enrollment Application.

10. IRS Name

Enter your IRS Name as it is registered with the IRS.

11. Social Security Number

The Social Security Number (SSN) of the individual provider if the provider is not personally incorporated under an Employee Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code. For identification purposes, you must furnish your social security number. Additionally, Sections 1124(a)(1) and 1124A of the Social Security Act require that you disclose your social security number to receive payment.

OR

12. Employer Tax ID Number

Enter your Employer Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code unless you are a member of a group that bills for services you render under the group Medicaid number, or you are individually incorporated.

13. Type of Applicant

Indicate the Type of Applicant: Individual, Limited Liability Partner, Sole Proprietorship, Corporation Partnership, Group Practice, or Hospital Based Physicians Health Maintenance Organization.

14. Facility Rating

Indicate whether the Facility is Profit, Non-Profit, or Not Applicable.

15. Facility Control

Indicate the Facility Control: State, Private, Public, City, Charity, or Not Applicable.

16. Fiscal Year End

The month in which your fiscal year ends and the effective dates of the fiscal year. If there is not an End Date, leave this blank.

17. Administrator's Name

The name of the administrator of your practice or facility.

18. Number of Beds

If you are an institution, enter the number of beds for each type.

19. CLIA Number (Laboratory Services)

To be in compliance with the Center for Medicare and Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) of 1998, all laboratory testing sites must have a CLIA certificate of waiver or certificate of registration to legally perform laboratory services rendered on or after September, 1992. If you perform laboratory services, attach a copy of the CLIA certificate of waiver or certificate of registration.

ALL FORMS MUST BE SIGNED AND DATED

First Health Services Corporation

ADDRESS FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

The Address Form allows providers to indicate their Servicing Address and where they would like to receive Department of Assistance Services correspondence, payments, and remittance advice. If publications are to be sent to a billing agent, business office or any address other than the Servicing Address, the provider is responsible for obtaining the information for review and abiding by the regulations set forth in the publications.

- Provider manuals, manual updates, and memoranda may be accessed via the Department of Medical Assistance Services website at www.dmas.virginia.gov.
- The EDI Manual and updates may be accessed via the First Health Services EDI website at http://virginia.fhsc.com.

1. Servicing Address (Mandatory)

Indicate the physical location (street address) of where the provider renders services. Post office box addresses are not acceptable. Your Enrollment Application will be returned if submitted with a post office box address in this section. If you have more that one servicing location, you must submit a completed Enrollment Application for each location. If the Servicing Address is the only address provided, all Department of Medical Assistance Services correspondence, payments, and Remittance Advice will be sent to the Servicing Address.

2. Mail-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services correspondence (manual updates, memoranda, etc.) sent. A post office box address is acceptable. If this section is left blank, correspondence will be sent to the Servicing Address.

3. Pay-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services payments for services rendered sent. A post office box address is acceptable. If this section is left blank, payments will be sent to the Remittance-To Address. If there is no entry in the Remittance-To address section, payments will be sent to the Servicing Address.

4. Remittance-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services Remittance Advice sent. A post office box address is acceptable. If this section is left blank, the Remittance Advice will be sent to the Pay-To Address. If there is no entry in the Pay-To Address section, the Remittance Advice will be sent to the Mail-To address. If there is no entry in the Mail-To address section, the Remittance Advice will be sent to the Servicing Address.

For First Health's Use Only

Tracking Number_____

Provider Number_____

Base ID_____

Provider Type _____

VIRGINIA MEDICAL ASSISTANCE PROGRAM PROVIDER ENROLLMENT APPLICATION

All applicants must fill out the Enrollment Application. The attached instructions contain the details that apply to each type of provider. A signed provider Participation Agreement is also required and must be submitted with each enrollment application.

THIS FORM IS TO BE USED FOR INITIAL AND ADDITIONAL ENROLLMENTS ONLY

1. **PROVIDER PROGRAM:** ___ Medicaid ___ Medallion ___ Medallion II ___ State and Local Hospital (SLH)

   ___ Client Medical Management (CMM)

   ___ Temporary Detention Order (TDO)

   ___ Family Access to Medical Insurance Security Plan (FAMIS)

2. **REQUESTED EFFECTIVE DATE OF ENROLLMENT** _____

3. **EXISTING VIRGINIA MEDICAID PROVIDER NUMBERS** _____ _____

   _____ _____ _____

4. **LEGAL BUSINESS NAME:** _____
   (If applicable, as registered with the Internal Revenue Service)

   OR

   INDIVIDUAL NAME: _____ **SUFFIX** _____ **TITLE** _____
   (Name of the provider who performs the service)

5. **LICENSE/CERTIFICATION NUMBER** _____ **LICENSING BOARD** _____

   ISSUING STATE AND ENTITY _____

6. **PRIMARY SPECIALTY** _____ **LICENSING BOARD** _____

   SECONDARY SPECIALTY _____ **LICENSING BOARD** _____

7. **FDA MAMMOGRAPHY CERTIFICATION NUMBER** _____

8. **UPIN (UNIQUE PHYSICIAN/PRACTITIONER IDENTIFICATION NUMBER)** _____

9. **DEA (DRUG ENFORCEMENT AGENCY) NUMBER FOR THIS LOCATION** _____

REMARKS:

_____

_____

_____

_____

10. IRS NAME _____

11. SOCIAL SECURITY NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

12. EMPLOYER TAX ID NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

13. TYPE OF APPLICANT (Please check one)

___ **Individual** ___ **Corporation** ___ **Hospital Based Physician** ___ **Sole Proprietorship**

___ **Group** ___ **Partnership** ___ **Health Maintenance Organization (HMO)**

___ **Limited Liability Partner**

14. FACILITY RATING (Please check one)

___ **Profit** ___ **Non-Profit** ___ **Not Applicable**

15. FACILITY CONTROL (Please check one)

___ **State** ___ **Private** ___ **Public**

___ **City** ___ **Charity** ___ **Not Applicable**

16. FISCAL YEAR END

Month _____ **Begin Date** _____ **End Date** _____

17. ADMINISTRATOR'S NAME _____

18. NUMBER OF BEDS

___ **NF** ___ **SNF-NF** ___ **SNF**

___ **ICF-MR** ___ **Non-Cert** ___ **Specialized Care**

19. CLIA NUMBER _____

SIGNATURE _____ **DATE** _____

REMARKS:

_____

_____

_____

_____

ADDRESS FORM

PROVIDER NAME _____ **TAX ID NUMBER** _____

SERVICING ADDRESS (Physical location where provider renders services)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

CORRESPONDENCE ADDRESS (This address will be used to send forms, memoranda, etc.)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

PAY TO ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

REMITTANCE ADVICE ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

SIGNATURE _____ **DATE** _____

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Durable Medical Equipment and Supplies Participation Agreement

This is to certify:

Provider Name _____ Medicaid Provider Number _____

on this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap be excluded from participation in, be denied the benefits of, or be subjected to discrimination in Section 504 of the Rehabilitation Act of 1973 (29 §USC 794) VMAP.
2. Services rendered must be those provided according to a physician's written order. Payment is to be made only to those providers who actually render the services. Upon accepting a Medicaid recipient as a patient, the provider agrees to supply all items prescribed and authorized for the recipient which the provider supplies to the general public.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General or his authorized representatives, and federal personnel will be permitted under reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment by VMAP at its established rates for services covered constitutes full payment on behalf of the recipient. The provider agrees not to submit additional charges to the recipient for services covered by VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.
6. The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
9. The provider of respiratory ventilator equipment agrees to provide authorized maintenance and preventive services for ventilators belonging to VMAP recipients.
10. This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.
11. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.

12. This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your licensing authority shall result in the termination of your Medicaid Participation Agreement.

For First Health's use *only*
Director, Division of Program Operations Date

Original Signature of Provider **Date**

First Health Services Corporation

HOME AND COMMUNITY-BASED CARE APPLICATION FOR PROVIDER STATUS AS A PERSONAL EMERGENCY RESPONSE SYSTEM PROVIDER

Name your agency will do business as:

_____

PART A. PREVIOUS PROVIDER EXPERIENCE

1. Type of Related Experience:

I request to be approved as a provider of Personal Emergency Response System provider.
My agency is currently a Virginia Medicaid-enrolled provider of Home Health, Hospital, Rehab, Hospice, Nursing Facility, Clinic or one of the Community-Based Care services.

Yes **No**

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

2. Please type or print the Administrator's Name:

_____

PART B. GENERAL INFORMATION

In accordance with Federal requirements, all providers of Home and Community-Based Care services must submit the following information to the Department of Medical Assistance Services. The information you provide in this section will help us identify information you send to us, and direct where we send critical information you will need as a provider. Please be sure you follow the directions and accurately note the information requested so that we can provide you with quality service.

ADMINISTRATIVE PERSONNEL (Fill in all that apply.)

_____ _____ _____

Person responsible for signing contract Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Chief Administrator On-site Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Other On-site Contact Person Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Chief Corporate Officer Title Phone number

_____ _____ _____

Other Corporate Contact Person Title Phone number

GEOGRAPHICAL AREAS TO BE SERVED

List Cities/Counties in which you intend to serve Medicaid-eligible recipients.

_____ _____ _____

_____ _____ _____

_____ _____ _____

OWNERSHIP (FILL IN COMPLETELY FOR ALL OWNERS. INCLUDE PERCENT OF OWNERSHIP OF EACH) For Non-Profit Entities Section 501(c) (3), list the board members.

LEGAL NAME	ADDRESS	%
_____	_____	_____
_____	_____	_____
_____	_____	_____

OWNER(S) PARTICIPATION IN OTHER FEDERALLY FUNDED PROGRAMS

Federal requirements stipulate that any person listed above in with 5 percent or more ownership of any other Medicaid provider agency or agency that participates in any of the programs established under Title V, XVII, or XX of the Social Security Act must disclose such ownership.

CHECK ONE: _____ N/A _____ APPLICABLE, COMPLETE THIS SECTION

NAME	AGENCY NAME	TYPE OF BUSINESS
_____	_____	_____
_____	_____	_____
_____	_____	_____

TYPE OF AGENCY (PLEASE CHECK ALL THAT APPLY)

Non-Profit	Proprietary	State or Local Government
____ Church Related	____ Single Proprietorship	____ State
____ Non-Profit Corporation	____ Partnership	____ County/City
____ Other Non-Profit Ownership	____ Corporation	____ Hospital (District Authority)
	____ Hospital/Nursing Facility	

CHECK ANY OF THE FOLLOWING SERVICES YOUR AGENCY PROVIDES:

____ Durable Medical Equipment ____ Home Health ____ Social Work Services ____Hospice
____ Rehabilitation Services ____ Case Management ____ Others _____

REQUIREMENTS AND SIGNATURE

Any changes which affect the accuracy of the information on this application must be reported promptly to the Community-Based Care Section of the Department of Medical Assistance Services.

Federal requirements stipulate that upon each submission of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any person (not limited to but including any owner, operator, manager and/or employee) associated with the agency who has been convicted of a criminal offense (misdemeanor and/or felony) must be made. It is the duty of the provider agency to make inquiry and screen individuals at the point of application for employment to comply with this section.
Has anyone associated with the agency (owner, operators, managers or employees) been convicted of a criminal offense? **Yes** **No** .
If yes, explain the type of offense, name and title of individual:

_____

_____

The signature below certifies the following:

- That the chief administrative agent understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services

- That there is neither a judgment nor pending action of insolvency or bankruptcy in a State or Federal Court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

- That the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services prior to completing this application.

- That the information within this application is accurate, truthful, and complete.

- That DMAS is authorized to make any contact or inquiries necessary to facilitate completion of the application process.

_____ _____
Print Name of person signing application Print title

_____ _____
Signature of person signing contract Date

PART C. CBC PROGRAM STAFF CREDENTIALS AND REQUIREMENTS

COMPLETE FOR PERSONAL EMERGENCY RESPONSE

You are responsible for assuring that PERS staff meet the following qualifications. A PERS provider must be a certified home health or personal care agency, a durable medical equipment provider, a hospital or a PERS manufacturer that has the responsibility to furnish, install, maintain, test, monitor, and service the PERS equipment, as required to keep it fully operational. It is the provider's responsibility to assure that any new professional staff is oriented to the service and have the policy, procedures and forms necessary to comply with DMAS requirements. The provider is responsible for instructing all staff, who provides services, of the requirements related to the performance of their duties.

The PERS provider must employ an emergency response center staff with fully trained operators, that are capable of receiving signals for help from a recipient's PERS equipment 24-hours a day, 365, or 366 days per year, to determine whether an emergency exists, and notify an emergency response organization or an emergency responder that the PERS recipient needs emergency help.

The PERS provider must have back up monitoring capacity in case primary system cannot handle incoming emergency signals.

A PERS provider must comply with all applicable Virginia statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the services to be performed.

Standards for PERS Equipment: All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center, after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the recipient.

1. List below the person who will be responsible for daily management of the Personal Emergency Response System and who they report to:

_____ _____ _____

Name Title Phone Number

Reports to: _____ _____

Phone Number

_____ _____ _____

Name Title Phone Number

Reports to: _____ _____

Phone Number

First Health Services Corporation

MAILING SUSPENSION REQUEST

SIGNATURE WAIVER

PHARMACY POINT-OF-SALE

Please review and check the blocks, which pertain to you:

- ☐ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid correspondence under the Medicaid provider number given below.
- ☐ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.
- ☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health
Services Corporation

REQUEST FOR TITLE XVIII (MEDICARE) INFORMATION

Medicare crossover payment information is an exchange of claim information between Medicare and Medicaid. If the Medicaid enrollee has Medicare as their Primary/Secondary carrier, the Medicare information is transferred to Medicaid for remaining payment, thus eliminating the need for claim submission. First Health Services is requesting information from you to automate the payment of claims paid by Medicare for Recipients that are also eligible under the Virginia Medical Assistance Program. Please indicate your Medicare number, if you have been assigned one, by your Medicare intermediary. You will not be reimbursed for Medicare crossover claims unless you supply this number. The Medicare number you indicate below will be the number that Medicaid will use to reimburse you for Medicare crossover claims. Please allow 30 days for processing of the Medicare Information Form and commencement of automated Medicare crossover.

PROVIDER NAME _____

MEDICAID PROVIDER NUMBER _____
LEAVE BLANK, IF NUMBER PENDING

MEDICARE CARRIER _____

MEDICARE PROVIDER NUMBER _____

TELEPHONE #_____

SIGNATURE_____ **DATE** _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health
Services Corporation

ELECTRONIC FUNDS TRANSFER

Would you like your Medicaid and FAMIS checks to be automatically deposited in the account of your choice? If you want to participate in the Electronic Funds Transfer (EFT) program, just complete the enclosed form, tape a voided check to the form and mail or fax it to First Health at the address given below.

The start-up of EFT for a provider includes a two-week test period in which the banking institution and First Health tests the accuracy of the transfer of funds to a provider's bank account and the resolution of any detected errors. There is not a disruption in the routine disbursement of Medicaid claim payments as a paper check is generated with the provider's Remittance Advice during the test period. Upon completion of testing, the weekly deposit of funds takes place on the first business day after the Remittance date, which is typically a Monday.

The First Health Services, EFT Enrollment Representative will track the enrollment of all providers in EFT and will monitor the process each week to detect problems that may arise.

Please keep in mind the following when enrolling for EFT:

- Submit an **original** signature.
- Submit one form for each provider number.
- **All** payments for the provider number must go to the same account.
- Processing time will be a minimum of 30 days from receipt of the completed form.

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

804-270-7027 (Fax)

First Health Services Corporation

Electronic Funds Transfer Application

GENERAL INFORMATION

Provider Name _____ Tax ID Number _____ Provider I.D. Number _____

Address _____ City _____ State _____ Zip _____

Authorization Agreement For Automatic Deposits (CREDITS)

I hereby authorize FIRST HEALTH **and its subsidiaries to initiate credit entries, if necessary, debit entries and adjustments for any credit in error for the following provider ID:**

Medicaid Provider ID	IRS Number

Printed Name _____ **Title** _____

Signature _____ **Date** _____

This authorization is to remain in full force until FIRST HEALTH **or the financial institution has received written notification from me and/or** FIRST HEALTH **of its cancellation in a timely manner so as to afford** FIRST HEALTH **and the financial institution a reasonable opportunity to act on it, or until the financial institution's cancellation of the agreement.**

☐ **Personal Account** ☐ **Business Account**

Place tape on this side ⟷

TAPE VOIDED CHECK HERE

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

http://www.dmas.virginia.gov

PERSONAL CARE

HOME AND COMMUNITY BASED CARE SERVICES

ENROLLMENT PACKAGE

Contents:

- Personal Care Enrollment Request Letter
- Personal Care Enrollment Instructions
- Personal Care Enrollment Application
- Home and Community Based Care Services Personal Care Participation Agreement
- Home and Community Based Care Application for Provider Status as a Personal Care Provider
- Mailing Suspension Request - Signature Waiver - Pharmacy POS Form
- Medicare Crossover Form
- Electronic Funds Transfer Informational Letter
- Electronic Funds Transfer Application

First Health Services Corporation

Fiscal Agent for Virginia's Medical Assistance Program – Provider Enrollment Unit

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Thank you for your request to participate in the Commonwealth of Virginia's Medical Assistance Program. Requesting to become a provider does not constitute automatic acceptance into the Program. Upon receipt of your completed Enrollment Application, processing of the enrollment may take up to 15 business days. First Health is unable to accept altered agreements or agreements without a signature. Additionally, the application will be returned if any portion is filled out incorrectly and/or missing information.

Enclosed is the Virginia Department of Medical Assistance Services, Provider Enrollment Application. This application is required for initial enrollment in any of the Virginia Medical Assistance Programs including the enrollment of additional locations. Each practice location must be enrolled separately. A completed Enrollment Application must include the Enrollment Application, Address Form, Participation Agreement, and any required licensure documents. If the requested date of enrollment is more than one year in the past, supporting documentation and a claim for services rendered must be submitted with the completed Enrollment Application.

Out-of-State Enrollment in Virginia Medical Assistance Programs

Adult Day Health Care providers must be located within the Commonwealth of Virginia. Out-of-state providers are not eligible for this Virginia Medical Assistance Program.

First Health Services Corporation (FHSC), fiscal agent for Virginia's Medical Assistance Program, administers all provider enrollment functions for Virginia Medicaid. First Health's Provider Enrollment Unit is available during the hours of 8:00 A.M. and 5:00 P.M. EST, Monday through Friday, to answer any enrollment questions you may have.

You may contact a Provider Enrollment Representative by calling:

1-888-829-5373 (In-state Toll Free)
OR
804-270-5105

Electronic copies of all Virginia Medicaid enrollment forms can be found at the Virginia Department of Medical Assistance Services website at (www.dmas.virginia.gov). **All applicants should visit the Virginia Department of Medical Assistance Services website and review the Personal/Respite Care Services and Elderly and Disabled Waiver Services Manuals for their specific provider participation requirements.** Completed Enrollment Applications should be mailed or faxed to First Health's Provider Enrollment Unit at the following address or fax number:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health Services Corporation

ENROLLMENT FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

1. Provider Program

The Virginia Medical Assistance Program(s) for which you are requesting enrollment. Note: Medallion II is the Virginia Medicaid Health Maintenance Organization (HMO) program.

2. Requested Effective Date of Enrollment

Enter the date that you are requesting your enrollment to begin.

3. Existing Virginia Medicaid Provider Numbers

If previously enrolled, list all Virginia Medicaid provider numbers assigned.

4. Legal Business Name.

The name of the business as registered with the Internal Revenue Service. This name is used to generate and report 1099 information each year. A provider doing business under his/her own name should leave this section blank.

Individual Provider Name.

Individual providers are enrolled under the last name, first name, middle initial and professional title (e.g., M.D.). This name is used to generate claim payments and report 1099 information.

5. License/Certification Number

The license number stated on your medical license from the **Virginia Department of Health Professions**. **Out-of-state providers must attach a legible copy of their licensure to the completed Enrollment Application.** If you have multiple licenses to report, please attach a separate sheet.

6. Specialty Codes

The primary specialty is first. Enter the date you were certified for your specialty. If you are certified in more than two specialties attach an additional sheet indicating the specialty and the effective dates. If you are a physician and you have a specialty, but do not include it on your Medicaid application, you will not be reimbursed for services that require a specialty certification for payment.

7. FDA Mammography Certification.

Enter your FDA Mammography Certification number. Enter the original issuance and expiration dates. You must include a legible copy of your FDA Mammography Certification with this application.

8. UPIN Number.

Enter your six (6) digit Medicare Universal Provider Identifier Number or your UPIN on this line, if available. **Enter the unique UPIN for the enrolled provider and not the same number for each provider in a practice.**

9. DEA Number.

Enter your Drug Enforcement Agency number. If applicable, attach a legible copy of your DEA license to the Enrollment Application.

10. IRS Name

Enter your IRS Name as it is registered with the IRS.

11. Social Security Number

The Social Security Number (SSN) of the individual provider if the provider is not personally incorporated under an Employee Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code. For identification purposes, you must furnish your social security number. Additionally, Sections 1124(a)(1) and 1124A of the Social Security Act require that you disclose your social security number to receive payment.

OR

12. Employer Tax ID Number

Enter your Employer Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code unless you are a member of a group that bills for services you render under the group Medicaid number, or you are individually incorporated.

13. Type of Applicant

Indicate the Type of Applicant: Individual, Limited Liability Partner, Sole Proprietorship, Corporation Partnership, Group Practice, or Hospital Based Physicians Health Maintenance Organization.

14. Facility Rating

Indicate whether the Facility is Profit, Non-Profit, or Not Applicable.

15. Facility Control

Indicate the Facility Control: State, Private, Public, City, Charity, or Not Applicable.

16. Fiscal Year End

The month in which your fiscal year ends and the effective dates of the fiscal year. If there is not an End Date, leave this blank.

17. Administrator's Name

The name of the administrator of your practice or facility.

18. Number of Beds

If you are an institution, enter the number of beds for each type.

19. CLIA Number (Laboratory Services)

To be in compliance with the Center for Medicare and Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) of 1998, all laboratory testing sites must have a CLIA certificate of waiver or certificate of registration to legally perform laboratory services rendered on or after September, 1992. If you perform laboratory services, attach a copy of the CLIA certificate of waiver or certificate of registration.

ALL FORMS MUST BE SIGNED AND DATED

First Health Services Corporation

ADDRESS FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

The Address Form allows providers to indicate their Servicing Address and where they would like to receive Department of Assistance Services correspondence, payments, and remittance advice. If publications are to be sent to a billing agent, business office or any address other than the Servicing Address, the provider is responsible for obtaining the information for review and abiding by the regulations set forth in the publications.

- Provider manuals, manual updates, and memoranda may be accessed via the Department of Medical Assistance Services website at www.dmas.virginia.gov.
- The EDI Manual and updates may be accessed via the First Health Services EDI website at http://virginia.fhsc.com.

1. Servicing Address (Mandatory)

Indicate the physical location (street address) of where the provider renders services. Post office box addresses are not acceptable. Your Enrollment Application will be returned if submitted with a post office box address in this section. If you have more that one servicing location, you must submit a completed Enrollment Application for each location. If the Servicing Address is the only address provided, all Department of Medical Assistance Services correspondence, payments, and Remittance Advice will be sent to the Servicing Address.

2. Mail-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services correspondence (manual updates, memoranda, etc.) sent. A post office box address is acceptable. If this section is left blank, correspondence will be sent to the Servicing Address.

3. Pay-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services payments for services rendered sent. A post office box address is acceptable. If this section is left blank, payments will be sent to the Remittance-To Address. If there is no entry in the Remittance-To address section, payments will be sent to the Servicing Address.

4. Remittance-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services Remittance Advice sent. A post office box address is acceptable. If this section is left blank, the Remittance Advice will be sent to the Pay-To Address. If there is no entry in the Pay-To Address section, the Remittance Advice will be sent to the Mail-To address. If there is no entry in the Mail-To address section, the Remittance Advice will be sent to the Servicing Address.

For First Health's Use Only

Tracking Number_____

Provider Number_____

Base ID_____

Provider Type _____

VIRGINIA MEDICAL ASSISTANCE PROGRAM PROVIDER ENROLLMENT APPLICATION

All applicants must fill out the Enrollment Application. The attached instructions contain the details that apply to each type of provider. A signed provider Participation Agreement is also required and must be submitted with each enrollment application.

THIS FORM IS TO BE USED FOR INITIAL AND ADDITIONAL ENROLLMENTS ONLY

1. **PROVIDER PROGRAM:** ___ Medicaid ___ Medallion ___ Medallion II ___ State and Local Hospital (SLH)

   ___ Client Medical Management (CMM)

   ___ Temporary Detention Order (TDO)

   ___ Family Access to Medical Insurance Security Plan (FAMIS)

2. **REQUESTED EFFECTIVE DATE OF ENROLLMENT** _____

3. **EXISTING VIRGINIA MEDICAID PROVIDER NUMBERS** _____ _____

   _____ _____ _____

4. **LEGAL BUSINESS NAME:** _____
   (If applicable, as registered with the Internal Revenue Service)

   OR

   INDIVIDUAL NAME: _____ **SUFFIX** _____ **TITLE** _____
   (Name of the provider who performs the service)

5. **LICENSE/CERTIFICATION NUMBER** _____ **LICENSING BOARD** _____

   ISSUING STATE AND ENTITY _____

6. **PRIMARY SPECIALTY** _____ **LICENSING BOARD** _____

   SECONDARY SPECIALTY _____ **LICENSING BOARD** _____

7. **FDA MAMMOGRAPHY CERTIFICATION NUMBER** _____

8. **UPIN (UNIQUE PHYSICIAN/PRACTITIONER IDENTIFICATION NUMBER)** _____

9. **DEA (DRUG ENFORCEMENT AGENCY) NUMBER FOR THIS LOCATION** _____

REMARKS:

_____

_____

_____

_____

10. IRS NAME _____

11. SOCIAL SECURITY NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

12. EMPLOYER TAX ID NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

13. TYPE OF APPLICANT (Please check one)

___ **Individual** ___ **Corporation** ___ **Hospital Based Physician** ___ **Sole Proprietorship**

___ **Group** ___ **Partnership** ___ **Health Maintenance Organization (HMO)**

___ **Limited Liability Partner**

14. FACILITY RATING (Please check one)

___ **Profit** ___ **Non-Profit** ___ **Not Applicable**

15. FACILITY CONTROL (Please check one)

___ **State** ___ **Private** ___ **Public**

___ **City** ___ **Charity** ___ **Not Applicable**

16. FISCAL YEAR END

Month _____ **Begin Date** _____ **End Date** _____

17. ADMINISTRATOR'S NAME _____

18. NUMBER OF BEDS

___ **NF** ___ **SNF-NF** ___ **SNF**

___ **ICF-MR** ___ **Non-Cert** ___ **Specialized Care**

19. CLIA NUMBER _____

SIGNATURE _____ **DATE** _____

REMARKS:

_____

_____

_____

_____

ADDRESS FORM

PROVIDER NAME _____ **TAX ID NUMBER** _____

SERVICING ADDRESS (Physical location where provider renders services)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

CORRESPONDENCE ADDRESS (This address will be used to send forms, memoranda, etc.)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

PAY TO ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

REMITTANCE ADVICE ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

SIGNATURE _____ **DATE** _____

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Home and Community Based Care Services Personal Care Participation Agreement

This is to certify:

Provider Name _____ Medicaid Provider Number _____

on this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider agrees to provide services in accordance with the Provider Participation Standards published periodically by DMAS in the appropriate Provider Manual(s), after being fully certified by DMAS to provide such services. In addition, the provider agrees that all individuals providing services under this Agreement meet the criteria set forth in the above referenced Provider Manual(s).**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794) no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in DMAS.**
3. **The provider agrees to keep such records as DMAS determines necessary. The provider will furnish DMAS on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized DMAS representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made under DMAS constitutes full payment on behalf of the recipient except for patient pay amounts determined by DMAS, and the provider agrees not to submit additional charges to the recipient for services covered under DMAS. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a DMAS recipient for any service provided under DMAS is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The provider agrees to pursue all other health care resources of payment prior to submitting a claim to DMAS.**
7. **Payment by DMAS at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider shall reimburse DMAS upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by DMAS when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.**
12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For First Health's use *only*
Director, Division of Program Operations Date

Original Signature of Provider **Date**

First Health Services Corporation

HOME AND COMMUNITY-BASED CARE APPLICATION FOR PROVIDER STATUS AS A PERSONAL CARE PROVIDER

Name your agency will do business as:

_____

PART A. PREVIOUS PROVIDER EXPERIENCE

1. Type of Related Experience:

I request to be approved as a provider of Personal Care services.
My agency is currently a Virginia Medicaid-enrolled provider of Home Health, Hospital, Rehab, Hospice, Nursing Facility, Clinic or one of the Community-Based Care services.

Yes **No**

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

2. Please type or print the Administrator's Name:

_____

PART B. GENERAL INFORMATION

In accordance with Federal requirements, all providers of Home and Community-Based Care services must submit the following information to the Department of Medical Assistance Services. The information you provide in this section will help us identify information you send to us, and direct where we send critical information you will need as a provider. Please be sure you follow the directions and accurately note the information requested so that we can provide you with quality service.

ADMINISTRATIVE PERSONNEL (Fill in all that apply.)

_____ _____ _____

Person responsible for signing contract Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Chief Administrator On-site Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Other On-site Contact Person Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Chief Corporate Officer Title Phone number

_____ _____ _____

Other Corporate Contact Person Title Phone number

GEOGRAPHICAL AREAS TO BE SERVED

List Cities/Counties in which you intend to serve Medicaid-eligible recipients.

_____ _____ _____

_____ _____ _____

_____ _____ _____

OWNERSHIP (FILL IN COMPLETELY FOR ALL OWNERS. INCLUDE PERCENT OF OWNERSHIP OF EACH) For Non-Profit Entities Section 501(c) (3), list the board members.

LEGAL NAME	ADDRESS	%
_____	_____	_____
_____	_____	_____
_____	_____	_____

OWNER(S) PARTICIPATION IN OTHER FEDERALLY FUNDED PROGRAMS

Federal requirements stipulate that any person listed above in with 5 percent or more ownership of any other Medicaid provider agency or agency that participates in any of the programs established under Title V, XVII, or XX of the Social Security Act must disclose such ownership.

CHECK ONE: _____ N/A _____ APPLICABLE, COMPLETE THIS SECTION

NAME	AGENCY NAME	TYPE OF BUSINESS
_____	_____	_____
_____	_____	_____
_____	_____	_____

TYPE OF AGENCY (PLEASE CHECK ALL THAT APPLY)

Non-Profit	Proprietary	State or Local Government
____ Church Related	____ Single Proprietorship	____ State
____ Non-Profit Corporation	____ Partnership	____ County/City
____ Other Non-Profit Ownership	____ Corporation	____ Hospital (District Authority)
	____ Hospital/Nursing Facility	

CHECK ANY OF THE FOLLOWING SERVICES YOUR AGENCY PROVIDES:

____ Durable Medical Equipment ____ Home Health ____ Social Work Services ____Hospice
____ Rehabilitation Services ____ Case Management ____ Others _____

REQUIREMENTS AND SIGNATURE

Any changes which affect the accuracy of the information on this application must be reported promptly to the Community-Based Care Section of the Department of Medical Assistance Services.

Federal requirements stipulate that upon each submission of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any person (not limited to but including any owner, operator, manager and/or employee) associated with the agency who has been convicted of a criminal offense (misdemeanor and/or felony) must be made. It is the duty of the provider agency to make inquiry and screen individuals at the point of application for employment to comply with this section.
Has anyone associated with the agency (owner, operators, managers or employees) been convicted of a criminal offense? **Yes** **No** .
If yes, explain the type of offense, name and title of individual:

_____

_____

The signature below certifies the following:

- That the chief administrative agent understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services

- That there is neither a judgment nor pending action of insolvency or bankruptcy in a State or Federal Court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

- That the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services prior to completing this application.

- That the information within this application is accurate, truthful, and complete.

- That DMAS is authorized to make any contact or inquiries necessary to facilitate completion of the application process.

_____ _____
Print Name of person signing application Print title

_____ _____
Signature of person signing contract Date

PART C. CBC PROGRAM STAFF CREDENTIALS AND REQUIREMENTS

COMPLETE FOR PERSONAL CARE

You are responsible for assuring that RN supervisory and aide staff meet the qualifications detailed in chapter II of the provider manual. All RN's who perform supervisory activities for the personal care program are expected to be knowledgeable of the personal care criteria, definitions for the completion of the functional status assessment and all program requirements, regardless of whether they perform these activities on a part time basis. It is the provider's responsibility to assure that any new RN staff who provides RN supervision for the personal care program is oriented to the program and have the policy, procedures and forms necessary to comply with DMAS requirements. The provider is responsible for instructing all aides who provide personal care in the program requirements related to their performance of duties.

1. **List below the person who will be responsible for daily management of the Personal Care program and who they report to:**

_____ _____ _____
Name Title Phone Number
Reports to: _____ _____
Phone Number

_____ _____ _____
Name Title Phone Number
Reports to: _____ _____
Phone Number

2. **Indicate the number of staff, both full time (FT) and part time (PT) you currently have hired to provide Personal Care.**

# FT	# PT		# FT	# PT	
___	___	**Registered Nurses**	___	___	**Personal Care Aides**

3. **Complete the following for each RN who will provide supervision, on either a full time or part time basis. In the FT/PT column, indicate the percent of time the RN will devote to the Personal Care program.**

Name	FT/PT	License #	Expiration Date	Amount/Type Clinical Experience

First Health Services Corporation

MAILING SUSPENSION REQUEST

SIGNATURE WAIVER

PHARMACY POINT-OF-SALE

Please review and check the blocks, which pertain to you:

- ☐ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid correspondence under the Medicaid provider number given below.
- ☐ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.
- ☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health
Services Corporation

REQUEST FOR TITLE XVIII (MEDICARE) INFORMATION

Medicare crossover payment information is an exchange of claim information between Medicare and Medicaid. If the Medicaid enrollee has Medicare as their Primary/Secondary carrier, the Medicare information is transferred to Medicaid for remaining payment, thus eliminating the need for claim submission. First Health Services is requesting information from you to automate the payment of claims paid by Medicare for Recipients that are also eligible under the Virginia Medical Assistance Program. Please indicate your Medicare number, if you have been assigned one, by your Medicare intermediary. You will not be reimbursed for Medicare crossover claims unless you supply this number. The Medicare number you indicate below will be the number that Medicaid will use to reimburse you for Medicare crossover claims. Please allow 30 days for processing of the Medicare Information Form and commencement of automated Medicare crossover.

PROVIDER NAME _____

MEDICAID PROVIDER NUMBER _____
LEAVE BLANK, IF NUMBER PENDING

MEDICARE CARRIER _____

MEDICARE PROVIDER NUMBER _____

TELEPHONE #_____

SIGNATURE_____ **DATE** _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health
Services Corporation

ELECTRONIC FUNDS TRANSFER

Would you like your Medicaid and FAMIS checks to be automatically deposited in the account of your choice? If you want to participate in the Electronic Funds Transfer (EFT) program, just complete the enclosed form, tape a voided check to the form and mail or fax it to First Health at the address given below.

The start-up of EFT for a provider includes a two-week test period in which the banking institution and First Health tests the accuracy of the transfer of funds to a provider's bank account and the resolution of any detected errors. There is not a disruption in the routine disbursement of Medicaid claim payments as a paper check is generated with the provider's Remittance Advice during the test period. Upon completion of testing, the weekly deposit of funds takes place on the first business day after the Remittance date, which is typically a Monday.

The First Health Services, EFT Enrollment Representative will track the enrollment of all providers in EFT and will monitor the process each week to detect problems that may arise.

Please keep in mind the following when enrolling for EFT:

- Submit an **original** signature.
- Submit one form for each provider number.
- **All** payments for the provider number must go to the same account.
- Processing time will be a minimum of 30 days from receipt of the completed form.

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

804-270-7027 (Fax)

First Health Services Corporation

Electronic Funds Transfer Application

GENERAL INFORMATION

Provider Name _____ Tax ID Number _____ Provider I.D. Number _____

Address _____ City _____ State _____ Zip _____

Authorization Agreement For Automatic Deposits (CREDITS)

I hereby authorize FIRST HEALTH **and its subsidiaries to initiate credit entries, if necessary, debit entries and adjustments for any credit in error for the following provider ID:**

Medicaid Provider ID	IRS Number

Printed Name _____ **Title** _____

Signature _____ **Date** _____

This authorization is to remain in full force until FIRST HEALTH **or the financial institution has received written notification from me and/or** FIRST HEALTH **of its cancellation in a timely manner so as to afford** FIRST HEALTH **and the financial institution a reasonable opportunity to act on it, or until the financial institution's cancellation of the agreement.**

☐ **Personal Account** ☐ **Business Account**

Place tape on this side ⟷

TAPE VOIDED CHECK HERE

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

http://www.dmas.virginia.gov

ADULT DAY HEALTH CARE

HOME AND COMMUNITY BASED CARE SERVICES

ENROLLMENT PACKAGE

Contents:

- Adult Day Health Care Enrollment Request Letter
- Adult Day Health Care Enrollment Instructions
- Adult Day Health Care Enrollment Application
- Home and Community Based Care Services Adult Day Health Care Participation Agreement
- Home and Community Based Care Application for Provider Status as an Adult Day Health Care Provider
- Mailing Suspension Request - Signature Waiver - Pharmacy POS Form
- Medicare Crossover Form
- Electronic Funds Transfer Informational Letter
- Electronic Funds Transfer Application

First Health Services Corporation

Fiscal Agent for Virginia's Medical Assistance Program – Provider Enrollment Unit

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Thank you for your request to participate in the Commonwealth of Virginia's Medical Assistance Program. Requesting to become a provider does not constitute automatic acceptance into the Program. Upon receipt of your completed Enrollment Application, processing of the enrollment may take up to 15 business days. First Health is unable to accept altered agreements or agreements without a signature. Additionally, the application will be returned if any portion is filled out incorrectly and/or missing information.

Enclosed is the Virginia Department of Medical Assistance Services, Provider Enrollment Application. This application is required for initial enrollment in any of the Virginia Medical Assistance Programs including the enrollment of additional locations. Each practice location must be enrolled separately. A completed Enrollment Application must include the Enrollment Application, Address Form, Participation Agreement, and any required licensure documents. **Adult Day Health Care providers must submit a copy of their Adult Day Care license from the Virginia Department of Social Services with their completed enrollment application.** If the requested date of enrollment is more than one year in the past, supporting documentation and a claim for services rendered must be submitted with the completed Enrollment Application.

Out-of-State Enrollment in Virginia Medical Assistance Programs

Adult Day Health Care providers must be located within the Commonwealth of Virginia. Out-of-state providers are not eligible for this Virginia Medical Assistance Program.

First Health Services Corporation (FHSC), fiscal agent for Virginia's Medical Assistance Program, administers all provider enrollment functions for Virginia Medicaid. First Health's Provider Enrollment Unit is available during the hours of 8:00 A.M. and 5:00 P.M. EST, Monday through Friday, to answer any enrollment questions you may have.

You may contact a Provider Enrollment Representative by calling:

1-888-829-5373 (In-state Toll Free)
OR
804-270-5105

Electronic copies of all Virginia Medicaid enrollment forms can be found at the Virginia Department of Medical Assistance Services website at (www.dmas.virginia.gov). **All applicants should visit the Virginia Department of Medical Assistance Services website and review the Elderly and Disabled – Waiver Services Manual for their specific provider participation requirements.** Completed Enrollment Applications should be mailed or faxed to First Health's Provider Enrollment Unit at the following address or fax number:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health Services Corporation

ENROLLMENT FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

1. Provider Program

The Virginia Medical Assistance Program(s) for which you are requesting enrollment. Note: Medallion II is the Virginia Medicaid Health Maintenance Organization (HMO) program.

2. Requested Effective Date of Enrollment

Enter the date that you are requesting your enrollment to begin.

3. Existing Virginia Medicaid Provider Numbers

If previously enrolled, list all Virginia Medicaid provider numbers assigned.

4. Legal Business Name.

The name of the business as registered with the Internal Revenue Service. This name is used to generate and report 1099 information each year. A provider doing business under his/her own name should leave this section blank.

Individual Provider Name.

Individual providers are enrolled under the last name, first name, middle initial and professional title (e.g., M.D.). This name is used to generate claim payments and report 1099 information.

5. License/Certification Number

The license number stated on your medical license from the **Virginia Department of Health Professions**. **Out-of-state providers must attach a legible copy of their licensure to the completed Enrollment Application.** If you have multiple licenses to report, please attach a separate sheet.

6. Specialty Codes

The primary specialty is first. Enter the date you were certified for your specialty. If you are certified in more than two specialties attach an additional sheet indicating the specialty and the effective dates. If you are a physician and you have a specialty, but do not include it on your Medicaid application, you will not be reimbursed for services that require a specialty certification for payment.

7. FDA Mammography Certification.

Enter your FDA Mammography Certification number. Enter the original issuance and expiration dates. You must include a legible copy of your FDA Mammography Certification with this application.

8. UPIN Number.

Enter your six (6) digit Medicare Universal Provider Identifier Number or your UPIN on this line, if available. **Enter the unique UPIN for the enrolled provider and not the same number for each provider in a practice.**

9. DEA Number.

Enter your Drug Enforcement Agency number. If applicable, attach a legible copy of your DEA license to the Enrollment Application.

10. IRS Name

Enter your IRS Name as it is registered with the IRS.

11. Social Security Number

The Social Security Number (SSN) of the individual provider if the provider is not personally incorporated under an Employee Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code. For identification purposes, you must furnish your social security number. Additionally, Sections 1124(a)(1) and 1124A of the Social Security Act require that you disclose your social security number to receive payment.

OR

12. Employer Tax ID Number

Enter your Employer Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code unless you are a member of a group that bills for services you render under the group Medicaid number, or you are individually incorporated.

13. Type of Applicant

Indicate the Type of Applicant: Individual, Limited Liability Partner, Sole Proprietorship, Corporation Partnership, Group Practice, or Hospital Based Physicians Health Maintenance Organization.

14. Facility Rating

Indicate whether the Facility is Profit, Non-Profit, or Not Applicable.

15. Facility Control

Indicate the Facility Control: State, Private, Public, City, Charity, or Not Applicable.

16. Fiscal Year End

The month in which your fiscal year ends and the effective dates of the fiscal year. If there is not an End Date, leave this blank.

17. Administrator's Name

The name of the administrator of your practice or facility.

18. Number of Beds

If you are an institution, enter the number of beds for each type.

19. CLIA Number (Laboratory Services)

To be in compliance with the Center for Medicare and Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) of 1998, all laboratory testing sites must have a CLIA certificate of waiver or certificate of registration to legally perform laboratory services rendered on or after September, 1992. If you perform laboratory services, attach a copy of the CLIA certificate of waiver or certificate of registration.

ALL FORMS MUST BE SIGNED AND DATED

First Health Services Corporation

ADDRESS FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

The Address Form allows providers to indicate their Servicing Address and where they would like to receive Department of Assistance Services correspondence, payments, and remittance advice. If publications are to be sent to a billing agent, business office or any address other than the Servicing Address, the provider is responsible for obtaining the information for review and abiding by the regulations set forth in the publications.

- Provider manuals, manual updates, and memoranda may be accessed via the Department of Medical Assistance Services website at www.dmas.virginia.gov.
- The EDI Manual and updates may be accessed via the First Health Services EDI website at http://virginia.fhsc.com.

1. Servicing Address (Mandatory)

Indicate the physical location (street address) of where the provider renders services. Post office box addresses are not acceptable. Your Enrollment Application will be returned if submitted with a post office box address in this section. If you have more that one servicing location, you must submit a completed Enrollment Application for each location. If the Servicing Address is the only address provided, all Department of Medical Assistance Services correspondence, payments, and Remittance Advice will be sent to the Servicing Address.

2. Mail-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services correspondence (manual updates, memoranda, etc.) sent. A post office box address is acceptable. If this section is left blank, correspondence will be sent to the Servicing Address.

3. Pay-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services payments for services rendered sent. A post office box address is acceptable. If this section is left blank, payments will be sent to the Remittance-To Address. If there is no entry in the Remittance-To address section, payments will be sent to the Servicing Address.

4. Remittance-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services Remittance Advice sent. A post office box address is acceptable. If this section is left blank, the Remittance Advice will be sent to the Pay-To Address. If there is no entry in the Pay-To Address section, the Remittance Advice will be sent to the Mail-To address. If there is no entry in the Mail-To address section, the Remittance Advice will be sent to the Servicing Address.

For First Health's Use Only

Tracking Number_____

Provider Number_____

Base ID_____

Provider Type _____

VIRGINIA MEDICAL ASSISTANCE PROGRAM PROVIDER ENROLLMENT APPLICATION

All applicants must fill out the Enrollment Application. The attached instructions contain the details that apply to each type of provider. A signed provider Participation Agreement is also required and must be submitted with each enrollment application.

THIS FORM IS TO BE USED FOR INITIAL AND ADDITIONAL ENROLLMENTS ONLY

1. **PROVIDER PROGRAM:** ___ Medicaid ___ Medallion ___ Medallion II ___ State and Local Hospital (SLH)

   ___ Client Medical Management (CMM)

   ___ Temporary Detention Order (TDO)

   ___ Family Access to Medical Insurance Security Plan (FAMIS)

2. **REQUESTED EFFECTIVE DATE OF ENROLLMENT** _____

3. **EXISTING VIRGINIA MEDICAID PROVIDER NUMBERS** _____ _____

   _____ _____ _____

4. **LEGAL BUSINESS NAME:** _____
   (If applicable, as registered with the Internal Revenue Service)

   OR

   INDIVIDUAL NAME: _____ **SUFFIX** _____ **TITLE** _____
   (Name of the provider who performs the service)

5. **LICENSE/CERTIFICATION NUMBER** _____ **LICENSING BOARD** _____

   ISSUING STATE AND ENTITY _____

6. **PRIMARY SPECIALTY** _____ **LICENSING BOARD** _____

   SECONDARY SPECIALTY _____ **LICENSING BOARD** _____

7. **FDA MAMMOGRAPHY CERTIFICATION NUMBER** _____

8. **UPIN (UNIQUE PHYSICIAN/PRACTITIONER IDENTIFICATION NUMBER)** _____

9. **DEA (DRUG ENFORCEMENT AGENCY) NUMBER FOR THIS LOCATION** _____

REMARKS:

_____

_____

_____

_____

10. IRS NAME _____

11. SOCIAL SECURITY NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

12. EMPLOYER TAX ID NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

13. TYPE OF APPLICANT (Please check one)

___ **Individual** ___ **Corporation** ___ **Hospital Based Physician** ___ **Sole Proprietorship**

___ **Group** ___ **Partnership** ___ **Health Maintenance Organization (HMO)**

___ **Limited Liability Partner**

14. FACILITY RATING (Please check one)

___ **Profit** ___ **Non-Profit** ___ **Not Applicable**

15. FACILITY CONTROL (Please check one)

___ **State** ___ **Private** ___ **Public**

___ **City** ___ **Charity** ___ **Not Applicable**

16. FISCAL YEAR END

Month _____ **Begin Date** _____ **End Date** _____

17. ADMINISTRATOR'S NAME _____

18. NUMBER OF BEDS

___ **NF** ___ **SNF-NF** ___ **SNF**

___ **ICF-MR** ___ **Non-Cert** ___ **Specialized Care**

19. CLIA NUMBER _____

SIGNATURE _____ **DATE** _____

REMARKS:

_____

_____

_____

_____

ADDRESS FORM

PROVIDER NAME _____ **TAX ID NUMBER** _____

SERVICING ADDRESS (Physical location where provider renders services)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

CORRESPONDENCE ADDRESS (This address will be used to send forms, memoranda, etc.)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

PAY TO ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

REMITTANCE ADVICE ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

SIGNATURE _____ **DATE** _____

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Home and Community Based Care Services Adult Day Health Care Participation Agreement

This is to certify:

Provider Name _____ Medicaid Provider Number _____

on this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider agrees to provide services in accordance with the Provider Participation Standards published periodically by DMAS in the appropriate Provider Manual(s), after being fully certified by DMAS to provide such services. In addition, the provider agrees that all individuals providing services under this Agreement meet the criteria set forth in the above referenced Provider Manual(s).**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794) no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in DMAS.**
3. **The provider agrees to keep such records as DMAS determines necessary. The provider will furnish DMAS on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized DMAS representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made under DMAS constitutes full payment on behalf of the recipient except for patient pay amounts determined by DMAS, and the provider agrees not to submit additional charges to the recipient for services covered under DMAS. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a DMAS recipient for any service provided under DMAS is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The provider agrees to pursue all other health care resources of payment prior to submitting a claim to DMAS.**
7. **Payment by DMAS at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider shall reimburse DMAS upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by DMAS when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.**
12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For First Health's use *only*
Director, Division of Program Operations Date

Original Signature of Provider **Date**

First Health Services Corporation

HOME AND COMMUNITY-BASED CARE APPLICATION FOR PROVIDER STATUS AS AN ADULT DAY HEALTH CARE PROVIDER

Name your agency will do business as:

_____

PART A. PREVIOUS PROVIDER EXPERIENCE

1. Type of Related Experience:

I request to be approved as a provider of Adult Day Health Care services.
My agency is currently a Virginia Medicaid-enrolled provider of Home Health, Hospital, Rehab, Hospice, Nursing Facility, Clinic or one of the Community-Based Care services.

Yes **No**

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

2. Please type or print the Administrator's Name:

_____

PART B. GENERAL INFORMATION

In accordance with Federal requirements, all providers of Home and Community-Based Care services must submit the following information to the Department of Medical Assistance Services. The information you provide in this section will help us identify information you send to us, and direct where we send critical information you will need as a provider. Please be sure you follow the directions and accurately note the information requested so that we can provide you with quality service.

ADMINISTRATIVE PERSONNEL (Fill in all that apply.)

_____ _____ _____

Person responsible for signing contract Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Chief Administrator On-site Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Other On-site Contact Person Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Chief Corporate Officer Title Phone number

_____ _____ _____

Other Corporate Contact Person Title Phone number

GEOGRAPHICAL AREAS TO BE SERVED

List Cities/Counties in which you intend to serve Medicaid-eligible recipients.

_____ _____ _____

_____ _____ _____

_____ _____ _____

OWNERSHIP (FILL IN COMPLETELY FOR ALL OWNERS. INCLUDE PERCENT OF OWNERSHIP OF EACH) For Non-Profit Entities Section 501(c) (3), list the board members.

LEGAL NAME	ADDRESS	%
_____	_____	_____
_____	_____	_____
_____	_____	_____

OWNER(S) PARTICIPATION IN OTHER FEDERALLY FUNDED PROGRAMS

Federal requirements stipulate that any person listed above in with 5 percent or more ownership of any other Medicaid provider agency or agency that participates in any of the programs established under Title V, XVII, or XX of the Social Security Act must disclose such ownership.

CHECK ONE: _____ N/A _____ APPLICABLE, COMPLETE THIS SECTION

NAME	AGENCY NAME	TYPE OF BUSINESS
_____	_____	_____
_____	_____	_____
_____	_____	_____

TYPE OF AGENCY (PLEASE CHECK ALL THAT APPLY)

Non-Profit	Proprietary	State or Local Government
____ Church Related	____ Single Proprietorship	____ State
____ Non-Profit Corporation	____ Partnership	____ County/City
____ Other Non-Profit Ownership	____ Corporation	____ Hospital (District Authority)
	____ Hospital/Nursing Facility	

CHECK ANY OF THE FOLLOWING SERVICES YOUR AGENCY PROVIDES:

____ Durable Medical Equipment ____ Home Health ____ Social Work Services ____Hospice
____ Rehabilitation Services ____ Case Management ____ Others _____

REQUIREMENTS AND SIGNATURE

Any changes which affect the accuracy of the information on this application must be reported promptly to the Community-Based Care Section of the Department of Medical Assistance Services.

Federal requirements stipulate that upon each submission of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any person (not limited to but including any owner, operator, manager and/or employee) associated with the agency who has been convicted of a criminal offense (misdemeanor and/or felony) must be made. It is the duty of the provider agency to make inquiry and screen individuals at the point of application for employment to comply with this section.
Has anyone associated with the agency (owner, operators, managers or employees) been convicted of a criminal offense? **Yes** **No** .
If yes, explain the type of offense, name and title of individual:

_____

_____

The signature below certifies the following:

- That the chief administrative agent understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services

- That there is neither a judgment nor pending action of insolvency or bankruptcy in a State or Federal Court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

- That the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services prior to completing this application.

- That the information within this application is accurate, truthful, and complete.

- That DMAS is authorized to make any contact or inquiries necessary to facilitate completion of the application process.

_____ _____
Print Name of person signing application Print title

_____ _____
Signature of person signing contract Date

PART C. CBC PROGRAM STAFF CREDENTIALS AND REQUIREMENTS

COMPLETE FOR ADULT DAY HEALTH CARE
A COPY OF THE DSS ADULT DAY CARE LICENSE MUST BE ATTACHED

You are responsible for assuring that ADHC program staff meet the qualifications detailed in chapter II of the provider manual. All professional staff who perform supervisory and/or coordination activities for the ADHC program are expected to be knowledgeable of the ADHC criteria, definitions for the completion of the functional status assessment and all program requirements, regardless of whether they perform these activities on a part time basis. It is the provider's responsibility to assure that any new professional staff is oriented to the program and have the policy, procedures and forms necessary to comply with DMAS requirements. The provider is responsible for instructing all aides who provide ADHC services of the program requirements related to their performance of duties.

1. **List below the person who will be responsible for daily management of the Adult Day Health Care program and who they report to:**

_____ _____ _____
Name Title Phone Number
Reports to: _____ _____
Phone Number

_____ _____ _____
Name Title Phone Number
Reports to: _____ _____
Phone Number

2. **Complete the following staffing information:**

Number of **Program Aides**: _____ full time _____ part time

_____ _____ _____ _____
RN Name License Number Expiration Date Amount/Type Clinical Experience

Activities Director Name: _____
Post high school education: _____ Number of hours per semester or quarter (circle one).
Obtained at educational institution: _____
Amount and type of experience: _____

Director Name: _____
Post high school education: _____ Number of hours per semester or quarter (circle one).
Obtained at educational institution: _____
Amount and type of experience: _____

3. **<u>Hours of Operation</u>** **<u>Days of the Week</u>**

_____ _____

First Health Services Corporation

MAILING SUSPENSION REQUEST

SIGNATURE WAIVER

PHARMACY POINT-OF-SALE

Please review and check the blocks, which pertain to you:

- ❑ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid correspondence under the Medicaid provider number given below.
- ❑ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.
- ❑ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health
Services Corporation

REQUEST FOR TITLE XVIII (MEDICARE) INFORMATION

Medicare crossover payment information is an exchange of claim information between Medicare and Medicaid. If the Medicaid enrollee has Medicare as their Primary/Secondary carrier, the Medicare information is transferred to Medicaid for remaining payment, thus eliminating the need for claim submission. First Health Services is requesting information from you to automate the payment of claims paid by Medicare for Recipients that are also eligible under the Virginia Medical Assistance Program. Please indicate your Medicare number, if you have been assigned one, by your Medicare intermediary. You will not be reimbursed for Medicare crossover claims unless you supply this number. The Medicare number you indicate below will be the number that Medicaid will use to reimburse you for Medicare crossover claims. Please allow 30 days for processing of the Medicare Information Form and commencement of automated Medicare crossover.

PROVIDER NAME _____

MEDICAID PROVIDER NUMBER _____
LEAVE BLANK, IF NUMBER PENDING

MEDICARE CARRIER _____

MEDICARE PROVIDER NUMBER _____

TELEPHONE #_____

SIGNATURE_____ **DATE** _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health
Services Corporation

ELECTRONIC FUNDS TRANSFER

Would you like your Medicaid and FAMIS checks to be automatically deposited in the account of your choice? If you want to participate in the Electronic Funds Transfer (EFT) program, just complete the enclosed form, tape a voided check to the form and mail or fax it to First Health at the address given below.

The start-up of EFT for a provider includes a two-week test period in which the banking institution and First Health tests the accuracy of the transfer of funds to a provider's bank account and the resolution of any detected errors. There is not a disruption in the routine disbursement of Medicaid claim payments as a paper check is generated with the provider's Remittance Advice during the test period. Upon completion of testing, the weekly deposit of funds takes place on the first business day after the Remittance date, which is typically a Monday.

The First Health Services, EFT Enrollment Representative will track the enrollment of all providers in EFT and will monitor the process each week to detect problems that may arise.

Please keep in mind the following when enrolling for EFT:

- Submit an **original** signature.
- Submit one form for each provider number.
- **All** payments for the provider number must go to the same account.
- Processing time will be a minimum of 30 days from receipt of the completed form.

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

804-270-7027 (Fax)

First Health Services Corporation

Electronic Funds Transfer Application

GENERAL INFORMATION

Provider Name	Tax ID Number	Provider I.D. Number

Address	City	State	Zip

Authorization Agreement For Automatic Deposits (CREDITS)

I hereby authorize FIRST HEALTH **and its subsidiaries to initiate credit entries, if necessary, debit entries and adjustments for any credit in error for the following provider ID:**

Medicaid Provider ID	IRS Number

Printed Name _____ **Title** _____

Signature _____ **Date** _____

This authorization is to remain in full force until FIRST HEALTH **or the financial institution has received written notification from me and/or** FIRST HEALTH **of its cancellation in a timely manner so as to afford** FIRST HEALTH **and the financial institution a reasonable opportunity to act on it, or until the financial institution's cancellation of the agreement.**

☐ **Personal Account** ☐ **Business Account**

Place tape on this side ⟷

TAPE VOIDED CHECK HERE

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

http://www.dmas.virginia.gov

RESPITE CARE

HOME AND COMMUNITY BASED CARE SERVICES

ENROLLMENT PACKAGE

Contents:

- Respite Care Enrollment Request Letter
- Respite Care Enrollment Instructions
- Respite Care Enrollment Application
- Home and Community Based Care Services Respite Care Participation Agreement
- Home and Community Based Care Application for Provider Status as a Respite Care Provider
- Mailing Suspension Request - Signature Waiver - Pharmacy POS Form
- Medicare Crossover Form
- Electronic Funds Transfer Informational Letter
- Electronic Funds Transfer Application

First Health Services Corporation

Fiscal Agent for Virginia's Medical Assistance Program – Provider Enrollment Unit

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Thank you for your request to participate in the Commonwealth of Virginia's Medical Assistance Program. Requesting to become a provider does not constitute automatic acceptance into the Program. Upon receipt of your completed Enrollment Application, processing of the enrollment may take up to 15 business days. First Health is unable to accept altered agreements or agreements without a signature. Additionally, the application will be returned if any portion is filled out incorrectly and/or missing information.

Enclosed is the Virginia Department of Medical Assistance Services, Provider Enrollment Application. This application is required for initial enrollment in any of the Virginia Medical Assistance Programs including the enrollment of additional locations. Each practice location must be enrolled separately. A completed Enrollment Application must include the Enrollment Application, Address Form, Participation Agreement, and any required licensure documents. If the requested date of enrollment is more than one year in the past, supporting documentation and a claim for services rendered must be submitted with the completed Enrollment Application.

Out-of-State Enrollment in Virginia Medical Assistance Programs

Adult Day Health Care providers must be located within the Commonwealth of Virginia. Out-of-state providers are not eligible for this Virginia Medical Assistance Program.

First Health Services Corporation (FHSC), fiscal agent for Virginia's Medical Assistance Program, administers all provider enrollment functions for Virginia Medicaid. First Health's Provider Enrollment Unit is available during the hours of 8:00 A.M. and 5:00 P.M. EST, Monday through Friday, to answer any enrollment questions you may have.

You may contact a Provider Enrollment Representative by calling:

1-888-829-5373 (In-state Toll Free)
OR
804-270-5105

Electronic copies of all Virginia Medicaid enrollment forms can be found at the Virginia Department of Medical Assistance Services website at (www.dmas.state.va.us). **All applicants should visit the Virginia Department of Medical Assistance Services website and review the Personal/Respite Care Services and Elderly and Disabled – Waiver Services Manuals for their specific provider participation requirements.** Completed Enrollment Applications should be mailed or faxed to First Health's Provider Enrollment Unit at the following address or fax number:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health Services Corporation

ENROLLMENT FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

1. Provider Program

The Virginia Medical Assistance Program(s) for which you are requesting enrollment. Note: Medallion II is the Virginia Medicaid Health Maintenance Organization (HMO) program.

2. Requested Effective Date of Enrollment

Enter the date that you are requesting your enrollment to begin.

3. Existing Virginia Medicaid Provider Numbers

If previously enrolled, list all Virginia Medicaid provider numbers assigned.

4. Legal Business Name.

The name of the business as registered with the Internal Revenue Service. This name is used to generate and report 1099 information each year. A provider doing business under his/her own name should leave this section blank.

Individual Provider Name.

Individual providers are enrolled under the last name, first name, middle initial and professional title (e.g., M.D.). This name is used to generate claim payments and report 1099 information.

5. License/Certification Number

The license number stated on your medical license from the **Virginia Department of Health Professions**. **Out-of-state providers must attach a legible copy of their licensure to the completed Enrollment Application.** If you have multiple licenses to report, please attach a separate sheet.

6. Specialty Codes

The primary specialty is first. Enter the date you were certified for your specialty. If you are certified in more than two specialties attach an additional sheet indicating the specialty and the effective dates. If you are a physician and you have a specialty, but do not include it on your Medicaid application, you will not be reimbursed for services that require a specialty certification for payment.

7. FDA Mammography Certification.

Enter your FDA Mammography Certification number. Enter the original issuance and expiration dates. You must include a legible copy of your FDA Mammography Certification with this application.

8. UPIN Number.

Enter your six (6) digit Medicare Universal Provider Identifier Number or your UPIN on this line, if available. **Enter the unique UPIN for the enrolled provider and not the same number for each provider in a practice.**

9. DEA Number.

Enter your Drug Enforcement Agency number. If applicable, attach a legible copy of your DEA license to the Enrollment Application.

10. IRS Name

Enter your IRS Name as it is registered with the IRS.

11. Social Security Number

The Social Security Number (SSN) of the individual provider if the provider is not personally incorporated under an Employee Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code. For identification purposes, you must furnish your social security number. Additionally, Sections 1124(a)(1) and 1124A of the Social Security Act require that you disclose your social security number to receive payment.

OR

12. Employer Tax ID Number

Enter your Employer Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code unless you are a member of a group that bills for services you render under the group Medicaid number, or you are individually incorporated.

13. Type of Applicant

Indicate the Type of Applicant: Individual, Limited Liability Partner, Sole Proprietorship, Corporation Partnership, Group Practice, or Hospital Based Physicians Health Maintenance Organization.

14. Facility Rating

Indicate whether the Facility is Profit, Non-Profit, or Not Applicable.

15. Facility Control

Indicate the Facility Control: State, Private, Public, City, Charity, or Not Applicable.

16. Fiscal Year End

The month in which your fiscal year ends and the effective dates of the fiscal year. If there is not an End Date, leave this blank.

17. Administrator's Name

The name of the administrator of your practice or facility.

18. Number of Beds

If you are an institution, enter the number of beds for each type.

19. CLIA Number (Laboratory Services)

To be in compliance with the Center for Medicare and Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) of 1998, all laboratory testing sites must have a CLIA certificate of waiver or certificate of registration to legally perform laboratory services rendered on or after September, 1992. If you perform laboratory services, attach a copy of the CLIA certificate of waiver or certificate of registration.

ALL FORMS MUST BE SIGNED AND DATED

First Health Services Corporation

ADDRESS FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

The Address Form allows providers to indicate their Servicing Address and where they would like to receive Department of Assistance Services correspondence, payments, and remittance advice. If publications are to be sent to a billing agent, business office or any address other than the Servicing Address, the provider is responsible for obtaining the information for review and abiding by the regulations set forth in the publications.

- Provider manuals, manual updates, and memoranda may be accessed via the Department of Medical Assistance Services website at www.dmas.state.va.us.
- The EDI Manual and updates may be accessed via the First Health Services EDI website at http://virginia.fhsc.com.

1. Servicing Address (Mandatory)

Indicate the physical location (street address) of where the provider renders services. Post office box addresses are not acceptable. Your Enrollment Application will be returned if submitted with a post office box address in this section. If you have more that one servicing location, you must submit a completed Enrollment Application for each location. If the Servicing Address is the only address provided, all Department of Medical Assistance Services correspondence, payments, and Remittance Advice will be sent to the Servicing Address.

2. Mail-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services correspondence (manual updates, memoranda, etc.) sent. A post office box address is acceptable. If this section is left blank, correspondence will be sent to the Servicing Address.

3. Pay-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services payments for services rendered sent. A post office box address is acceptable. If this section is left blank, payments will be sent to the Remittance-To Address. If there is no entry in the Remittance-To address section, payments will be sent to the Servicing Address.

4. Remittance-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services Remittance Advice sent. A post office box address is acceptable. If this section is left blank, the Remittance Advice will be sent to the Pay-To Address. If there is no entry in the Pay-To Address section, the Remittance Advice will be sent to the Mail-To address. If there is no entry in the Mail-To address section, the Remittance Advice will be sent to the Servicing Address.

For First Health's Use Only

Tracking Number_____

Provider Number_____

Base ID_____

Provider Type _____

VIRGINIA MEDICAL ASSISTANCE PROGRAM PROVIDER ENROLLMENT APPLICATION

All applicants must fill out the Enrollment Application. The attached instructions contain the details that apply to each type of provider. A signed provider Participation Agreement is also required and must be submitted with each enrollment application.

THIS FORM IS TO BE USED FOR INITIAL AND ADDITIONAL ENROLLMENTS ONLY

1. **PROVIDER PROGRAM:** ___ Medicaid ___ Medallion ___ Medallion II ___ State and Local Hospital (SLH)

   ___ Client Medical Management (CMM)

   ___ Temporary Detention Order (TDO)

   ___ Family Access to Medical Insurance Security Plan (FAMIS)

2. **REQUESTED EFFECTIVE DATE OF ENROLLMENT** _____

3. **EXISTING VIRGINIA MEDICAID PROVIDER NUMBERS** _____ _____

   _____ _____ _____

4. **LEGAL BUSINESS NAME:** _____
   (If applicable, as registered with the Internal Revenue Service)

   OR

   INDIVIDUAL NAME: _____ **SUFFIX** _____ **TITLE** _____
   (Name of the provider who performs the service)

5. **LICENSE/CERTIFICATION NUMBER** _____ **LICENSING BOARD** _____

   ISSUING STATE AND ENTITY _____

6. **PRIMARY SPECIALTY** _____ **LICENSING BOARD** _____

   SECONDARY SPECIALTY _____ **LICENSING BOARD** _____

7. **FDA MAMMOGRAPHY CERTIFICATION NUMBER** _____

8. **UPIN (UNIQUE PHYSICIAN/PRACTITIONER IDENTIFICATION NUMBER)** _____

9. **DEA (DRUG ENFORCEMENT AGENCY) NUMBER FOR THIS LOCATION** _____

REMARKS:

_____

_____

_____

_____

10. IRS NAME _____

11. SOCIAL SECURITY NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

12. EMPLOYER TAX ID NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

13. TYPE OF APPLICANT (Please check one)

___ **Individual** ___ **Corporation** ___ **Hospital Based Physician** ___ **Sole Proprietorship**

___ **Group** ___ **Partnership** ___ **Health Maintenance Organization (HMO)**

___ **Limited Liability Partner**

14. FACILITY RATING (Please check one)

___ **Profit** ___ **Non-Profit** ___ **Not Applicable**

15. FACILITY CONTROL (Please check one)

___ **State** ___ **Private** ___ **Public**

___ **City** ___ **Charity** ___ **Not Applicable**

16. FISCAL YEAR END

Month _____ **Begin Date** _____ **End Date** _____

17. ADMINISTRATOR'S NAME _____

18. NUMBER OF BEDS

___ **NF** ___ **SNF-NF** ___ **SNF**

___ **ICF-MR** ___ **Non-Cert** ___ **Specialized Care**

19. CLIA NUMBER _____

SIGNATURE _____ **DATE** _____

REMARKS:

_____

_____

_____

_____

ADDRESS FORM

PROVIDER NAME _____ **TAX ID NUMBER** _____

SERVICING ADDRESS (Physical location where provider renders services)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

CORRESPONDENCE ADDRESS (This address will be used to send forms, memoranda, etc.)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

PAY TO ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

REMITTANCE ADVICE ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

SIGNATURE _____ **DATE** _____

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Home and Community Based Care Services Respite Care Participation Agreement

This is to certify:

Provider Name _____ Medicaid Provider Number _____

on this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider agrees to provide services in accordance with the Provider Participation Standards published periodically by DMAS in the appropriate Provider Manual(s), after being fully certified by DMAS to provide such services. In addition, the provider agrees that all individuals providing services under this Agreement meet the criteria set forth in the above referenced Provider Manual(s).**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794) no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in DMAS.**
3. **The provider agrees to keep such records as DMAS determines necessary. The provider will furnish DMAS on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized DMAS representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made under DMAS constitutes full payment on behalf of the recipient except for patient pay amounts determined by DMAS, and the provider agrees not to submit additional charges to the recipient for services covered under DMAS. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a DMAS recipient for any service provided under DMAS is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The provider agrees to pursue all other health care resources of payment prior to submitting a claim to DMAS.**
7. **Payment by DMAS at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider shall reimburse DMAS upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by DMAS when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.**
12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For First Health's use *only*
Director, Division of Program Operations Date

Original Signature of Provider **Date**

First Health Services Corporation

HOME AND COMMUNITY-BASED CARE APPLICATION FOR PROVIDER STATUS AS AN RESPITE CARE PROVIDER

Name your agency will do business as:

_____

PART A. PREVIOUS PROVIDER EXPERIENCE

1. Type of Related Experience:

I request to be approved as a provider of Respite Care services.
My agency is currently a Virginia Medicaid-enrolled provider of Home Health, Hospital, Rehab, Hospice, Nursing Facility, Clinic or one of the Community-Based Care services.

Yes **No**

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

2. Please type or print the Administrator's Name:

_____

PART B. GENERAL INFORMATION

In accordance with Federal requirements, all providers of Home and Community-Based Care services must submit the following information to the Department of Medical Assistance Services. The information you provide in this section will help us identify information you send to us, and direct where we send critical information you will need as a provider. Please be sure you follow the directions and accurately note the information requested so that we can provide you with quality service.

ADMINISTRATIVE PERSONNEL (Fill in all that apply.)

_____ _____ _____

Person responsible for signing contract Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Chief Administrator On-site Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Other On-site Contact Person Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Chief Corporate Officer Title Phone number

_____ _____ _____

Other Corporate Contact Person Title Phone number

GEOGRAPHICAL AREAS TO BE SERVED

List Cities/Counties in which you intend to serve Medicaid-eligible recipients.

_____ _____ _____

_____ _____ _____

_____ _____ _____

OWNERSHIP (FILL IN COMPLETELY FOR ALL OWNERS. INCLUDE PERCENT OF OWNERSHIP OF EACH) For Non-Profit Entities Section 501(c) (3), list the board members.

LEGAL NAME	ADDRESS	%
_____	_____	_____
_____	_____	_____
_____	_____	_____

OWNER(S) PARTICIPATION IN OTHER FEDERALLY FUNDED PROGRAMS

Federal requirements stipulate that any person listed above in with 5 percent or more ownership of any other Medicaid provider agency or agency that participates in any of the programs established under Title V, XVII, or XX of the Social Security Act must disclose such ownership.

CHECK ONE: _____ N/A _____ APPLICABLE, COMPLETE THIS SECTION

NAME	AGENCY NAME	TYPE OF BUSINESS
_____	_____	_____
_____	_____	_____
_____	_____	_____

TYPE OF AGENCY (PLEASE CHECK ALL THAT APPLY)

Non-Profit	Proprietary	State or Local Government
____ Church Related	____ Single Proprietorship	____ State
____ Non-Profit Corporation	____ Partnership	____ County/City
____ Other Non-Profit Ownership	____ Corporation	____ Hospital (District Authority)
	____ Hospital/Nursing Facility	

CHECK ANY OF THE FOLLOWING SERVICES YOUR AGENCY PROVIDES:

____ Durable Medical Equipment ____ Home Health ____ Social Work Services ____Hospice
____ Rehabilitation Services ____ Case Management ____ Others _____

REQUIREMENTS AND SIGNATURE

Any changes which affect the accuracy of the information on this application must be reported promptly to the Community-Based Care Section of the Department of Medical Assistance Services.

Federal requirements stipulate that upon each submission of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any person (not limited to but including any owner, operator, manager and/or employee) associated with the agency who has been convicted of a criminal offense (misdemeanor and/or felony) must be made. It is the duty of the provider agency to make inquiry and screen individuals at the point of application for employment to comply with this section.
Has anyone associated with the agency (owner, operators, managers or employees) been convicted of a criminal offense? **Yes** **No** .
If yes, explain the type of offense, name and title of individual:

_____

_____

The signature below certifies the following:

- That the chief administrative agent understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services

- That there is neither a judgment nor pending action of insolvency or bankruptcy in a State or Federal Court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

- That the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services prior to completing this application.

- That the information within this application is accurate, truthful, and complete.

- That DMAS is authorized to make any contact or inquiries necessary to facilitate completion of the application process.

_____ _____
Print Name of person signing application Print title

_____ _____
Signature of person signing contract Date

PART C. CBC PROGRAM STAFF CREDENTIALS AND REQUIREMENTS

COMPLETE FOR RESPITE CARE

You are responsible for assuring that RN supervisory and aide staff meet the qualifications detailed in chapter II of the provider manual. All RN's who perform supervisory activities for the personal care program are expected to be knowledgeable of the personal care criteria, definitions for the completion of the functional status assessment and all program requirements, regardless of whether they perform these activities on a part time basis. It is the provider's responsibility to assure that any new RN staff who provides RN supervision for the personal care program is oriented to the program and have the policy, procedures and forms necessary to comply with DMAS requirements. The provider is responsible for instructing all aides who provide personal care in the program requirements related to their performance of duties.

1. **List below the person who will be responsible for daily management of the Respite Care program and who they report to:**

_____ _____ _____
Name Title Phone Number
Reports to: _____ _____
Phone Number

_____ _____ _____
Name Title Phone Number
Reports to: _____ _____
Phone Number

2. **Indicate the number of staff, both full time (FT) and part time (PT) you currently have hired to provide Respite Care.**

# FT	# PT		# FT	# PT	
___	___	**Registered Nurses**	___	___	**Personal Care Aides**

3. **Complete the following for each RN who will provide supervision, on either a full time or part time basis. In the FT/PT column, indicate the percent of time the RN will devote to the Respite Care program.**

Name	FT/PT	License #	Expiration Date	Amount/Type Clinical Experience

First Health Services Corporation

MAILING SUSPENSION REQUEST

SIGNATURE WAIVER

PHARMACY POINT-OF-SALE

Please review and check the blocks, which pertain to you:

- ☐ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid correspondence under the Medicaid provider number given below.
- ☐ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.
- ☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health
Services Corporation

REQUEST FOR TITLE XVIII (MEDICARE) INFORMATION

Medicare crossover payment information is an exchange of claim information between Medicare and Medicaid. If the Medicaid enrollee has Medicare as their Primary/Secondary carrier, the Medicare information is transferred to Medicaid for remaining payment, thus eliminating the need for claim submission. First Health Services is requesting information from you to automate the payment of claims paid by Medicare for Recipients that are also eligible under the Virginia Medical Assistance Program. Please indicate your Medicare number, if you have been assigned one, by your Medicare intermediary. You will not be reimbursed for Medicare crossover claims unless you supply this number. The Medicare number you indicate below will be the number that Medicaid will use to reimburse you for Medicare crossover claims. Please allow 30 days for processing of the Medicare Information Form and commencement of automated Medicare crossover.

PROVIDER NAME _____

MEDICAID PROVIDER NUMBER _____
LEAVE BLANK, IF NUMBER PENDING

MEDICARE CARRIER _____

MEDICARE PROVIDER NUMBER _____

TELEPHONE #_____

SIGNATURE_____ **DATE** _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health
Services Corporation

ELECTRONIC FUNDS TRANSFER

Would you like your Medicaid and FAMIS checks to be automatically deposited in the account of your choice? If you want to participate in the Electronic Funds Transfer (EFT) program, just complete the enclosed form, tape a voided check to the form and mail or fax it to First Health at the address given below.

The start-up of EFT for a provider includes a two-week test period in which the banking institution and First Health tests the accuracy of the transfer of funds to a provider's bank account and the resolution of any detected errors. There is not a disruption in the routine disbursement of Medicaid claim payments as a paper check is generated with the provider's Remittance Advice during the test period. Upon completion of testing, the weekly deposit of funds takes place on the first business day after the Remittance date, which is typically a Monday.

The First Health Services, EFT Enrollment Representative will track the enrollment of all providers in EFT and will monitor the process each week to detect problems that may arise.

Please keep in mind the following when enrolling for EFT:

- Submit an **original** signature.
- Submit one form for each provider number.
- **All** payments for the provider number must go to the same account.
- Processing time will be a minimum of 30 days from receipt of the completed form.

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

804-270-7027 (Fax)

First Health Services Corporation

Electronic Funds Transfer Application

GENERAL INFORMATION

Provider Name _____ Tax ID Number _____ Provider I.D. Number _____

Address _____ City _____ State _____ Zip _____

Authorization Agreement For Automatic Deposits (CREDITS)

I hereby authorize FIRST HEALTH **and its subsidiaries to initiate credit entries, if necessary, debit entries and adjustments for any credit in error for the following provider ID:**

Medicaid Provider ID	IRS Number

Printed Name _____ **Title** _____

Signature _____ **Date** _____

This authorization is to remain in full force until FIRST HEALTH **or the financial institution has received written notification from me and/or** FIRST HEALTH **of its cancellation in a timely manner so as to afford** FIRST HEALTH **and the financial institution a reasonable opportunity to act on it, or until the financial institution's cancellation of the agreement.**

☐ **Personal Account** ☐ **Business Account**

Place tape on this side ⟷

TAPE VOIDED CHECK HERE

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

http://www.dmas.virginia.gov

CONSUMER DIRECTED SERVICE COORDINATOR

HOME AND COMMUNITY BASED CARE SERVICES

ENROLLMENT PACKAGE

Contents:

- Consumer Directed Service Coordinator Enrollment Request Letter
- Consumer Directed Service Coordinator Enrollment Instructions
- Consumer Directed Service Coordinator Enrollment Application
- Home and Community Based Care Services Consumer Directed Service Coordinator Care Participation Agreement
- Home and Community Based Care Application for Provider Status as a Consumer Directed Service Coordinator Provider
- Mailing Suspension Request - Signature Waiver - Pharmacy POS Form
- Medicare Crossover Form
- Electronic Funds Transfer Informational Letter
- Electronic Funds Transfer Application

First Health Services Corporation

Fiscal Agent for Virginia's Medical Assistance Program – Provider Enrollment Unit

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Thank you for your request to participate in the Commonwealth of Virginia's Medical Assistance Program. Requesting to become a provider does not constitute automatic acceptance into the Program. Upon receipt of your completed Enrollment Application, processing of the enrollment may take up to 15 business days. First Health is unable to accept altered agreements or agreements without a signature. Additionally, the application will be returned if any portion is filled out incorrectly and/or missing information.

Enclosed is the Virginia Department of Medical Assistance Services, Provider Enrollment Application. This application is required for initial enrollment in any of the Virginia Medical Assistance Programs including the enrollment of additional locations. Each practice location must be enrolled separately. A completed Enrollment Application must include the Enrollment Application, Address Form, Participation Agreement, and any required licensure documents. If the requested date of enrollment is more than one year in the past, supporting documentation and a claim for services rendered must be submitted with the completed Enrollment Application.

Out-of-State Enrollment in Virginia Medical Assistance Programs

Adult Day Health Care providers must be located within the Commonwealth of Virginia. Out-of-state providers are not eligible for this Virginia Medical Assistance Program.

First Health Services Corporation (FHSC), fiscal agent for Virginia's Medical Assistance Program, administers all provider enrollment functions for Virginia Medicaid. First Health's Provider Enrollment Unit is available during the hours of 8:00 A.M. and 5:00 P.M. EST, Monday through Friday, to answer any enrollment questions you may have.

You may contact a Provider Enrollment Representative by calling:

1-888-829-5373 (In-state Toll Free)
OR
804-270-5105

Electronic copies of all Virginia Medicaid enrollment forms can be found at the Virginia Department of Medical Assistance Services website at (www.dmas.virginia.gov). **All applicants should visit the Virginia Department of Medical Assistance Services website and review the Consumer Directed Personal Attendant Services Manual for their specific provider participation requirements.** Completed Enrollment Applications should be mailed or faxed to First Health's Provider Enrollment Unit at the following address or fax number:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health Services Corporation

ENROLLMENT FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

1. Provider Program

The Virginia Medical Assistance Program(s) for which you are requesting enrollment. Note: Medallion II is the Virginia Medicaid Health Maintenance Organization (HMO) program.

2. Requested Effective Date of Enrollment

Enter the date that you are requesting your enrollment to begin.

3. Existing Virginia Medicaid Provider Numbers

If previously enrolled, list all Virginia Medicaid provider numbers assigned.

4. Legal Business Name.

The name of the business as registered with the Internal Revenue Service. This name is used to generate and report 1099 information each year. A provider doing business under his/her own name should leave this section blank.

Individual Provider Name.

Individual providers are enrolled under the last name, first name, middle initial and professional title (e.g., M.D.). This name is used to generate claim payments and report 1099 information.

5. License/Certification Number

The license number stated on your medical license from the **Virginia Department of Health Professions**. **Out-of-state providers must attach a legible copy of their licensure to the completed Enrollment Application.** If you have multiple licenses to report, please attach a separate sheet.

6. Specialty Codes

The primary specialty is first. Enter the date you were certified for your specialty. If you are certified in more than two specialties attach an additional sheet indicating the specialty and the effective dates. If you are a physician and you have a specialty, but do not include it on your Medicaid application, you will not be reimbursed for services that require a specialty certification for payment.

7. FDA Mammography Certification.

Enter your FDA Mammography Certification number. Enter the original issuance and expiration dates. You must include a legible copy of your FDA Mammography Certification with this application.

8. UPIN Number.

Enter your six (6) digit Medicare Universal Provider Identifier Number or your UPIN on this line, if available. **Enter the unique UPIN for the enrolled provider and not the same number for each provider in a practice.**

9. DEA Number.

Enter your Drug Enforcement Agency number. If applicable, attach a legible copy of your DEA license to the Enrollment Application.

10. IRS Name

Enter your IRS Name as it is registered with the IRS.

11. Social Security Number

The Social Security Number (SSN) of the individual provider if the provider is not personally incorporated under an Employee Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code. For identification purposes, you must furnish your social security number. Additionally, Sections 1124(a)(1) and 1124A of the Social Security Act require that you disclose your social security number to receive payment.

OR

12. Employer Tax ID Number

Enter your Employer Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code unless you are a member of a group that bills for services you render under the group Medicaid number, or you are individually incorporated.

13. Type of Applicant

Indicate the Type of Applicant: Individual, Limited Liability Partner, Sole Proprietorship, Corporation Partnership, Group Practice, or Hospital Based Physicians Health Maintenance Organization.

14. Facility Rating

Indicate whether the Facility is Profit, Non-Profit, or Not Applicable.

15. Facility Control

Indicate the Facility Control: State, Private, Public, City, Charity, or Not Applicable.

16. Fiscal Year End

The month in which your fiscal year ends and the effective dates of the fiscal year. If there is not an End Date, leave this blank.

17. Administrator's Name

The name of the administrator of your practice or facility.

18. Number of Beds

If you are an institution, enter the number of beds for each type.

19. CLIA Number (Laboratory Services)

To be in compliance with the Center for Medicare and Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) of 1998, all laboratory testing sites must have a CLIA certificate of waiver or certificate of registration to legally perform laboratory services rendered on or after September, 1992. If you perform laboratory services, attach a copy of the CLIA certificate of waiver or certificate of registration.

ALL FORMS MUST BE SIGNED AND DATED

First Health Services Corporation

ADDRESS FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

The Address Form allows providers to indicate their Servicing Address and where they would like to receive Department of Assistance Services correspondence, payments, and remittance advice. If publications are to be sent to a billing agent, business office or any address other than the Servicing Address, the provider is responsible for obtaining the information for review and abiding by the regulations set forth in the publications.

- Provider manuals, manual updates, and memoranda may be accessed via the Department of Medical Assistance Services website at www.dmas.virginia.gov.
- The EDI Manual and updates may be accessed via the First Health Services EDI website at http://virginia.fhsc.com.

1. Servicing Address (Mandatory)

Indicate the physical location (street address) of where the provider renders services. Post office box addresses are not acceptable. Your Enrollment Application will be returned if submitted with a post office box address in this section. If you have more that one servicing location, you must submit a completed Enrollment Application for each location. If the Servicing Address is the only address provided, all Department of Medical Assistance Services correspondence, payments, and Remittance Advice will be sent to the Servicing Address.

2. Mail-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services correspondence (manual updates, memoranda, etc.) sent. A post office box address is acceptable. If this section is left blank, correspondence will be sent to the Servicing Address.

3. Pay-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services payments for services rendered sent. A post office box address is acceptable. If this section is left blank, payments will be sent to the Remittance-To Address. If there is no entry in the Remittance-To address section, payments will be sent to the Servicing Address.

4. Remittance-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services Remittance Advice sent. A post office box address is acceptable. If this section is left blank, the Remittance Advice will be sent to the Pay-To Address. If there is no entry in the Pay-To Address section, the Remittance Advice will be sent to the Mail-To address. If there is no entry in the Mail-To address section, the Remittance Advice will be sent to the Servicing Address.

For First Health's Use Only
Tracking Number_____
Provider Number_____
Base ID_____
Provider Type _____

VIRGINIA MEDICAL ASSISTANCE PROGRAM PROVIDER ENROLLMENT APPLICATION

All applicants must fill out the Enrollment Application. The attached instructions contain the details that apply to each type of provider. A signed provider Participation Agreement is also required and must be submitted with each enrollment application.

THIS FORM IS TO BE USED FOR INITIAL AND ADDITIONAL ENROLLMENTS ONLY

1. **PROVIDER PROGRAM:** ___ Medicaid ___ Medallion ___ Medallion II ___ State and Local Hospital (SLH)
   ___ Client Medical Management (CMM)
   ___ Temporary Detention Order (TDO)
   ___ Family Access to Medical Insurance Security Plan (FAMIS)
2. **REQUESTED EFFECTIVE DATE OF ENROLLMENT** _____
3. **EXISTING VIRGINIA MEDICAID PROVIDER NUMBERS** _____ _____
   _____ _____ _____
4. **LEGAL BUSINESS NAME:** _____
   (If applicable, as registered with the Internal Revenue Service)
   OR
   INDIVIDUAL NAME: _____ **SUFFIX** _____ **TITLE** _____
   (Name of the provider who performs the service)
5. **LICENSE/CERTIFICATION NUMBER** _____ **LICENSING BOARD** _____
   ISSUING STATE AND ENTITY _____
6. **PRIMARY SPECIALTY** _____ **LICENSING BOARD** _____
   SECONDARY SPECIALTY _____ **LICENSING BOARD** _____
7. **FDA MAMMOGRAPHY CERTIFICATION NUMBER** _____
8. **UPIN (UNIQUE PHYSICIAN/PRACTITIONER IDENTIFICATION NUMBER)** _____
9. **DEA (DRUG ENFORCEMENT AGENCY) NUMBER FOR THIS LOCATION** _____

REMARKS:
_____
_____
_____
_____

10. IRS NAME _____

11. SOCIAL SECURITY NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

12. EMPLOYER TAX ID NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

13. TYPE OF APPLICANT (Please check one)

___ **Individual** ___ **Corporation** ___ **Hospital Based Physician** ___ **Sole Proprietorship**

___ **Group** ___ **Partnership** ___ **Health Maintenance Organization (HMO)**

___ **Limited Liability Partner**

14. FACILITY RATING (Please check one)

___ **Profit** ___ **Non-Profit** ___ **Not Applicable**

15. FACILITY CONTROL (Please check one)

___ **State** ___ **Private** ___ **Public**

___ **City** ___ **Charity** ___ **Not Applicable**

16. FISCAL YEAR END

Month _____ **Begin Date** _____ **End Date** _____

17. ADMINISTRATOR'S NAME _____

18. NUMBER OF BEDS

___ **NF** ___ **SNF-NF** ___ **SNF**

___ **ICF-MR** ___ **Non-Cert** ___ **Specialized Care**

19. CLIA NUMBER _____

SIGNATURE _____ **DATE** _____

REMARKS:

_____

_____

_____

_____

ADDRESS FORM

PROVIDER NAME _____ **TAX ID NUMBER** _____

SERVICING ADDRESS (Physical location where provider renders services)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

CORRESPONDENCE ADDRESS (This address will be used to send forms, memoranda, etc.)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

PAY TO ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

REMITTANCE ADVICE ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

SIGNATURE _____ **DATE** _____

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Home and Community Based Care Services
Consumer Directed Service Coordinator Participation Agreement

This is to certify:

Provider Name _____ Medicaid Provider Number _____

on this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider agrees to provide services in accordance with the Provider Participation Standards published periodically by DMAS in the appropriate Provider Manual(s), after being fully certified by DMAS to provide such services. In addition, the provider agrees that all individuals providing services under this Agreement meet the criteria set forth in the above referenced Provider Manual(s).**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794) no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in DMAS.**
3. **The provider agrees to keep such records as DMAS determines necessary. The provider will furnish DMAS on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized DMAS representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made under DMAS constitutes full payment on behalf of the recipient except for patient pay amounts determined by DMAS, and the provider agrees not to submit additional charges to the recipient for services covered under DMAS. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a DMAS recipient for any service provided under DMAS is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The provider agrees to pursue all other health care resources of payment prior to submitting a claim to DMAS.**
7. **Payment by DMAS at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider shall reimburse DMAS upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by DMAS when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.**
12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For First Health's use *only*
Director, Division of Program Operations Date

Original Signature of Provider **Date**

First Health Services Corporation

HOME AND COMMUNITY-BASED CARE APPLICATION FOR PROVIDER STATUS AS A CONSUMER DIRECTED SERVICES COORDINATOR PROVIDER

Name your agency will do business as:

_____

PART A. PREVIOUS PROVIDER EXPERIENCE

1. Type of Related Experience:

I request to be approved as a provider of Consumer Directed Coordination Services.
My agency is currently a Virginia Medicaid-enrolled provider of Home Health, Hospital, Rehab, Hospice, Nursing Facility, Clinic or one of the Community-Based Care services.

Yes **No**

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

2. Please type or print the Administrator's Name:

_____

PART B. GENERAL INFORMATION

In accordance with Federal requirements, all providers of Home and Community-Based Care services must submit the following information to the Department of Medical Assistance Services. The information you provide in this section will help us identify information you send to us, and direct where we send critical information you will need as a provider. Please be sure you follow the directions and accurately note the information requested so that we can provide you with quality service.

ADMINISTRATIVE PERSONNEL (Fill in all that apply.)

_____ _____ _____

Person responsible for signing contract Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Chief Administrator On-site Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Other On-site Contact Person Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Chief Corporate Officer Title Phone number

_____ _____ _____

Other Corporate Contact Person Title Phone number

GEOGRAPHICAL AREAS TO BE SERVED

List Cities/Counties in which you intend to serve Medicaid-eligible recipients.

_____ _____ _____

_____ _____ _____

_____ _____ _____

OWNERSHIP (FILL IN COMPLETELY FOR ALL OWNERS. INCLUDE PERCENT OF OWNERSHIP OF EACH) For Non-Profit Entities Section 501(c) (3), list the board members.

LEGAL NAME	ADDRESS	%
_____	_____	_____
_____	_____	_____
_____	_____	_____

OWNER(S) PARTICIPATION IN OTHER FEDERALLY FUNDED PROGRAMS

Federal requirements stipulate that any person listed above in with 5 percent or more ownership of any other Medicaid provider agency or agency that participates in any of the programs established under Title V, XVII, or XX of the Social Security Act must disclose such ownership.

CHECK ONE: _____ N/A _____ APPLICABLE, COMPLETE THIS SECTION

NAME	AGENCY NAME	TYPE OF BUSINESS
_____	_____	_____
_____	_____	_____
_____	_____	_____

TYPE OF AGENCY (PLEASE CHECK ALL THAT APPLY)

Non-Profit	Proprietary	State or Local Government
____ Church Related	____ Single Proprietorship	____ State
____ Non-Profit Corporation	____ Partnership	____ County/City
____ Other Non-Profit Ownership	____ Corporation	____ Hospital (District Authority)
	____ Hospital/Nursing Facility	

CHECK ANY OF THE FOLLOWING SERVICES YOUR AGENCY PROVIDES:

____ Durable Medical Equipment ____ Home Health ____ Social Work Services ____Hospice
____ Rehabilitation Services ____ Case Management ____ Others _____

REQUIREMENTS AND SIGNATURE

Any changes which affect the accuracy of the information on this application must be reported promptly to the Community-Based Care Section of the Department of Medical Assistance Services.

Federal requirements stipulate that upon each submission of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any person (not limited to but including any owner, operator, manager and/or employee) associated with the agency who has been convicted of a criminal offense (misdemeanor and/or felony) must be made. It is the duty of the provider agency to make inquiry and screen individuals at the point of application for employment to comply with this section.
Has anyone associated with the agency (owner, operators, managers or employees) been convicted of a criminal offense? **Yes** **No** .
If yes, explain the type of offense, name and title of individual:

_____

_____

The signature below certifies the following:

- That the chief administrative agent understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services

- That there is neither a judgment nor pending action of insolvency or bankruptcy in a State or Federal Court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

- That the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services prior to completing this application.

- That the information within this application is accurate, truthful, and complete.

- That DMAS is authorized to make any contact or inquiries necessary to facilitate completion of the application process.

_____ _____
Print Name of person signing application Print title

_____ _____
Signature of person signing contract Date

PART C. CBC PROGRAM STAFF CREDENTIALS AND REQUIREMENTS

COMPLETE FOR CONSUMER-DIRECTED SERVICE COORDINATOR

You are responsible for assuring that service facilitator (SF) staff meet the qualifications detailed in chapter II of the provider manual. All SF's who perform supervisory activities for the Consumer-Directed Service Coordinator, are expected to be knowledgeable of the Consumer-Directed Service Coordinator Services, definitions for the completion of the functional status assessment and all program requirements, regardless of whether they perform these activities on a part time basis. It is the provider's responsibility to assure that any new SC staff, for the Consumer-Directed Service Coordinator Program, are oriented to the program and have the policy, procedures and forms necessary to comply with DMAS requirements. The provider is responsible for instructing all recipients of Consumer-Directed Service Coordinator care in the program requirements related to their performance of duties as employers.

1. **List below the person, who, will be responsible for daily management of the Consumer-Directed Service Coordinator Program(s) and who they report to:**

_____ _____ _____

Name Title Phone Number

Reports to: _____ _____

Phone Number

_____ _____ _____

Name Title Phone Number

Reports to: _____ _____

Phone Number

2. **Complete the following for each Service Coordinator who will provide supervision, on either a full time or part time basis. In the space under FT/PT, indicate the percent of time the SC will devote to the Consumer-Directed Service Coordinator Program.**

FT/PT or Contracted	SC Name	Degree/Type of License/License Number	Expiration Date	Amount/Type of Clinical Experience

First Health Services Corporation

MAILING SUSPENSION REQUEST

SIGNATURE WAIVER

PHARMACY POINT-OF-SALE

Please review and check the blocks, which pertain to you:

- ☐ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid correspondence under the Medicaid provider number given below.
- ☐ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.
- ☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health
Services Corporation

REQUEST FOR TITLE XVIII (MEDICARE) INFORMATION

Medicare crossover payment information is an exchange of claim information between Medicare and Medicaid. If the Medicaid enrollee has Medicare as their Primary/Secondary carrier, the Medicare information is transferred to Medicaid for remaining payment, thus eliminating the need for claim submission. First Health Services is requesting information from you to automate the payment of claims paid by Medicare for Recipients that are also eligible under the Virginia Medical Assistance Program. Please indicate your Medicare number, if you have been assigned one, by your Medicare intermediary. You will not be reimbursed for Medicare crossover claims unless you supply this number. The Medicare number you indicate below will be the number that Medicaid will use to reimburse you for Medicare crossover claims. Please allow 30 days for processing of the Medicare Information Form and commencement of automated Medicare crossover.

PROVIDER NAME _____

MEDICAID PROVIDER NUMBER _____
LEAVE BLANK, IF NUMBER PENDING

MEDICARE CARRIER _____

MEDICARE PROVIDER NUMBER _____

TELEPHONE #_____

SIGNATURE_____ **DATE** _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health
Services Corporation

ELECTRONIC FUNDS TRANSFER

Would you like your Medicaid and FAMIS checks to be automatically deposited in the account of your choice? If you want to participate in the Electronic Funds Transfer (EFT) program, just complete the enclosed form, tape a voided check to the form and mail or fax it to First Health at the address given below.

The start-up of EFT for a provider includes a two-week test period in which the banking institution and First Health tests the accuracy of the transfer of funds to a provider's bank account and the resolution of any detected errors. There is not a disruption in the routine disbursement of Medicaid claim payments as a paper check is generated with the provider's Remittance Advice during the test period. Upon completion of testing, the weekly deposit of funds takes place on the first business day after the Remittance date, which is typically a Monday.

The First Health Services, EFT Enrollment Representative will track the enrollment of all providers in EFT and will monitor the process each week to detect problems that may arise.

Please keep in mind the following when enrolling for EFT:

- Submit an **original** signature.
- Submit one form for each provider number.
- **All** payments for the provider number must go to the same account.
- Processing time will be a minimum of 30 days from receipt of the completed form.

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

804-270-7027 (Fax)

First Health Services Corporation

Electronic Funds Transfer Application

GENERAL INFORMATION

Provider Name _____ Tax ID Number _____ Provider I.D. Number _____

Address _____ City _____ State _____ Zip _____

Authorization Agreement For Automatic Deposits (CREDITS)

I hereby authorize FIRST HEALTH **and its subsidiaries to initiate credit entries, if necessary, debit entries and adjustments for any credit in error for the following provider ID:**

Medicaid Provider ID	IRS Number

Printed Name _____ **Title** _____

Signature _____ **Date** _____

This authorization is to remain in full force until FIRST HEALTH **or the financial institution has received written notification from me and/or** FIRST HEALTH **of its cancellation in a timely manner so as to afford** FIRST HEALTH **and the financial institution a reasonable opportunity to act on it, or until the financial institution's cancellation of the agreement.**

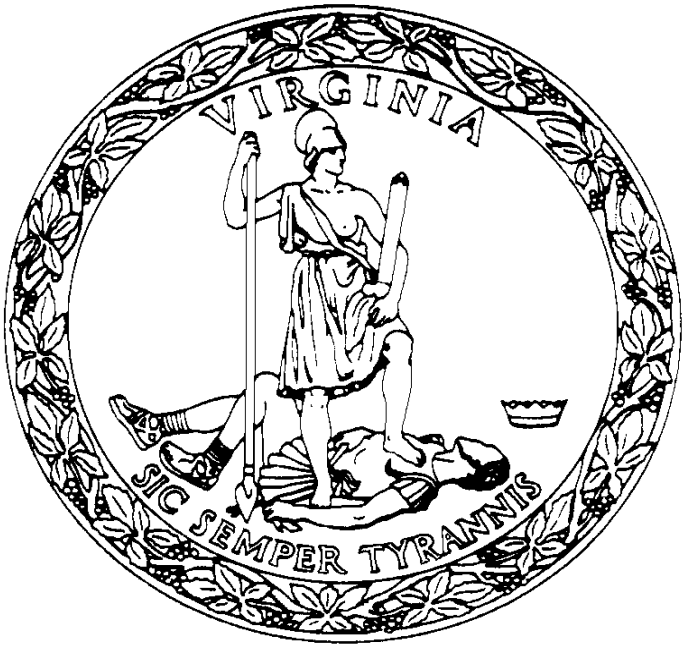
☐ **Personal Account** ☐ **Business Account**

Place tape on this side ⟷

TAPE VOIDED CHECK HERE

Department of Medical Assistance Services

Personal Care Aide Training Curriculum



2003

Foreword

The Virginia Department of Medical Assistance Services (DMAS) allows provider agencies to develop a Personal Care Aide (PCA) training program within their agency. The purpose is to assist providers in recruiting, effectively training, and retaining nursing aides to provide services to Medicaid Waiver recipients.

DMAS has developed this curriculum to be used by providers who desire to have a PCA training program within their agency. In the past Medicaid required providers to submit a copy of their PCA training curriculum to the Long Term Care and Quality Assurance Division of DMAS for approval.

Beginning July 1, 2002, all agencies that have not previously received a letter of approval and authorization must use this curriculum as a part of their training program. The provider must complete and submit the Request for Authorization form (DMAS-260) and receive a letter of authorization from the Waiver Services Unit (WSU) at DMAS, and use this curriculum as a part of their program. All authorized programs will be added to the list of Medicaid approved PCA training programs. This list is regularly updated and posted on the DMAS web site.

The DMAS Personal Care Aide training program must give a minimum of 40-hours of nursing aide training and be supervised and taught by a RN who is currently licensed to practice in the Commonwealth of Virginia. The RN must have at least two (2) years of related clinical experience as a Registered Nurse or as a Licensed Practical Nurse (LPN). Clinical experience may include work in an acute care hospital, public health clinic, home health agency, or nursing facility.

Graduates of this PCA program are only authorized to provide personal care nursing aide services to Medicaid Waiver recipients. All students must understand that this program will not be recognized by the Virginia State Board of Nursing, nursing and medical facilities, or other state nursing boards, but only by DMAS Waiver programs.

The personal care aide training class may include any number of students; however there must be a ratio of one (1) instructor to every ten (10) students. The purpose is to ensure adequate training and instruction for each student.

This aide training curriculum is not intended to include all information and practical training that is appropriate for personal care nursing aides. This outlined curriculum is information that DMAS is requiring as a part of the training program. DMAS created this curriculum to ensure that certain issues and subjects are taught to students who will be providing Medicaid services. All techniques, procedures, tasks, and assigned duties within this curriculum should be demonstrated and observed by the trainer prior to assigning the nursing aide to an independent setting such as a recipient's

home. The Appendix includes a skills check list and a test to be used at the end of the training. These documents can be altered to include any specific requirements of a locality or training area.

DMAS suggests contacting other resources to assist with the training, such as the police and fire department to put on in-services for the students in areas of safety. There are aspects of caring for a recipient in the community that the aides may not be aware of, such as how to remove a bed-bound recipient from the home in the case of a fire. The trainer may want to include some education on Hospice, death and dying, or any other topics that would assist the aide in providing quality care to the recipient.

If you have any questions, concerns, or would like assistance with this curriculum, please contact the Waiver Services Unit at (804) 786-1465.

Waiver Services Unit
Long Term Care and
Quality Assurance Division

The Department of Medical Assistance Services

PERSONAL CARE AIDE CURRICULUM

I. Introduction

A. This program has been developed by the Department of Medical Assistance Services (DMAS) to establish a uniform training curriculum. Its purpose is to train and teach qualified persons to provide personal care services under Medicaid Waivers. DMAS hopes that this program will assist in recruiting and retaining qualified personal care aides.

B. DMAS Requirements for Personal Care Aides (PCA) include:

1. Must be 18 years of age or older;
2. Must be able to read and write in English to the degree necessary to perform the tasks expected; and
3. Must be able to perform the tasks required.

II. The Elderly

A. Physical and Biological Aspects of Aging

1. Cardiovascular changes:

a. The heart rate slows, causing a slower pulse and less efficient circulation[1]

b. Blood vessels lose elasticity and develop calcium deposits, resulting in narrowing[1]

c. Blood pressure increases because of changes to the walls of the blood vessels[1]

d. It takes longer for the heart rate to return to normal after exercise[1]

e. Veins become enlarged, causing the blood vessels near the surface of the skin to become more prominent.[1]

2. Respiratory Changes:

a. Lung capacity is decreased because of muscular rigidity in the lungs[2]

b. Cough becomes less effective, allowing pooling of secretions and fluid[2] *in the lungs, increasing the risk of infection*[2]

c. Shortness of breath may occur on exertion[2]

d. Less effective gas exchange takes place in the lungs[2]

3. Urinary System Changes:

a. Bladder capacity decreases, increasing the frequency of urination[3]

b. Kidney function increases at rest, causing the elderly to get up during the night to urinate[3]

c. *Bladder muscles weaken, causing leaking of urine or inadequate emptying of the bladder*[3]

d. *The prostate gland (found in men) frequently enlarges, increasing the frequency of urination and causing dribbling, urinary obstruction, and urinary retention*[3]

4. Digestive System Changes:

   a. *Saliva production in the mouth decreases, interfering with digestion of starch*[4]

   b. *Taste buds on the tongue decrease, beginning with sweet and salt*[4]

   c. *The gag reflex in the throat is less effective, increasing the risk of choking*[4]

   d. *Movement of food into the stomach through the esophagus is slower*[4]

   e. *The stomach takes longer to empty into the small intestine, so food remains there longer*[4]

   f. *Fewer digestive enzymes are present in the stomach, causing indigestion and slower absorption of fat*[4]

5. Nervous System Changes:

   a. *More time is needed for tasks involving speed, balance, coordination, and fine motor activities, such as those involving fingers*[5]

   b. *Problems develop with balance and coordination as a result of deterioration of the nerve terminals that provide information to the brain on the movement and position of the body*[5]

   c. *The lens in the eye becomes less flexible, causing visual changes*[5]

   d. *Decreased secretion of fluid in the eye causes dryness and itching*[5]

   e. *Nerves and blood supply to the ears decrease, causing a difficulty hearing*[5]

   f. *There is a decrease in the ability to feel pressure and temperature, resulting in a higher potential for injury*[5]

   g. *Blood flow to the brain decreases, which may result in mental confusion and memory loss*[5]

6. Musculoskeletal Changes:

   a. *A decrease in strength, endurance, muscle tone, and reaction time is caused by loss of elasticity of muscles, and decrease in muscle mass*[6]

   b. *Bones lose minerals, become brittle, and break more easily*[6]

   c. *The spine is less stable, less flexible, and more easily injured*[6]

d. Posture may become poor because of weakness in back muscles[6]

e. Degenerative changes, or deterioration, occur in the joints, resulting in limited movement, stiffness, and pain[6]

7. Integumentary (Skin) Changes:

a. The skin thins and becomes less elastic; wrinkles appear, and the skin becomes irritated and breaks more easily[7]

b. Blood vessels that nourish the skin become more fragile and break more easily, resulting in bruising, senile purpura, and skin tears[7]

c. Blood flow in vessels that nourish the skin is reduced resulting in slower healing[7]

d. Oil glands that supply the skin secrete less, causing drying of the skin and itching[7]

e. Perspiration decreases, and the body's ability to regulate temperature is impaired[7]

f. Subcutaneous fat diminishes[7]

g. Blood supply to the feet and legs is diminished[7]

h. Fingernail and toenail growth slows and nails become brittle[7]

i. Hair thins and turns gray[7]

8. Endocrine System Changes:

a. Blood sugar level increases because of delayed release of insulin, a hormone that regulates sugar use in the body[9]

b. The amount of calories needed for the body to function normally decreases because of a lower metabolism rate, or slower body function[9]

9. Reproductive System Changes:

a. Hormone production decreases, causing decreased size of testes, and a lower sperm count[9]

b. More time is needed for an erection to occur[9]

c. *Fewer female hormones are produced*[9]

d. The vagina becomes shorter and narrower[9]

e. Vaginal secretions decrease[9]

f. Breast tissue decreases and the muscles supporting the breasts weaken[9]

B. Psychological Aspects of Aging

1. There are many factors that contribute to the psychological aspects of aging. These include, loss of income, loss of home, loss of independence, loss of spouse, illness or disease, loss of sense of security, and the loss of trust.
2. There are numerous behaviors due to psychological factors. These include, poor appetite, depression, anger, and insomnia.

C. Physical and Emotional Needs of the Elderly

1. Basic Human Needs:
   a. *Physiological needs-food, water, sleep, rest, physical activity, elimination, and oxygen*[10]
   b. *Safety and security-safe and protected from harm in the environment*[10]
   c. *Personal security in his or her family, relationships, and job. Financial security*[10]
   d. *Love and belonging-give love and receive love from others. Show recipient you care and accept him or her, regardless of disability, condition, appearance, or behavior. Provide privacy during care, treatments, and procedures, and respect the recipient's dignity*[10]
   e. *Self-esteem and respect-feel important and worthwhile; self-image may be threatened which may result in the recipient complaining frequently. The threat to self-esteem may result in recipient reacting with anger*[10]
   f. *Self-actualization-feeling a sense of accomplishment and success*[10]

D. Critical Situations that the Personal/Respite Care Aide may be Involved

1. Verbally abusive – The PCA is in the home to give care, support, and understanding. He/she would not be in the home if the recipient did not need professional medical assistance. The PCA must always maintain professionalism, and never verbally attack the recipient.
2. Combative - The PCA is never, under any circumstances, to hit a recipient. Usually, if you leave the recipient alone for a few minutes and then return and greet him/her, as if it were the first time you had seen him/her that day, he/she may have calmed down.
3. Emergency - The PCA must be aware at all times of the recipient and what is happening with him/her. The recipient may stop breathing, have a heart attack, stroke, a diabetic complication, or other physical or psychological emergency. The PCA must be prepared with a plan of action in case of an emergency. Depending on the problem, the PCA should know when it is

appropriate to call 911, the recipient's physician, a family member, and/or the personal care agency.

E. Orientation to Types of Physical Disabilities or Handicaps

The aide may encounter the following:

1. Rheumatoid Arthritis – This is a severely crippling and painful disease. Patience and gentleness must be used when moving, turning, bathing, or dressing the recipient;
2. Stroke – This may result in slurred speech, difficulty swallowing, paralysis in one extremity, paralysis on one side of the body, or total paralysis. The PCA needs to ensure skill of transfers and, if necessary, the use of a Lift;
3. Heart trouble – The recipient may show signs of chest pain on exertion, sweating, nausea, pain in the left arm, jaw, shoulder blade, and may become short of breath easily; and
4. Alzheimer's – This can manifest in a variety of ways. Many people with Alzheimer's may wander off, and therefore will need to be monitored at all times. They may present a danger to themselves and others by attempting to perform tasks and then forgetting what they were doing. One example is in the attempt to cook, and the stove is left on. Recipients with Alzheimer's may also be combative at times and not be aware of their actions.

III. Personal Care and Rehabilitative Services

A. Body Mechanics

1. Use of proper body mechanics by the personal care aide will prevent injury to the PCA and the recipient, and utilize the safest and often the easiest way to move/transfer the recipient.
2. Limitations on the personal care aide to activities - The aide should always be aware of any skilled needs of the recipient, which may have an impact on positioning. The PCA should also be aware of any restrictions on the recipient's activity and functioning ability.
3. Techniques of body mechanics (Demonstration of these techniques is necessary for proper training.)
    a. Helping the recipient sit up in bed - Make sure the bed is in its lowest position. If it is a manual bed, squat down to reach the handle, do not bend over. If the recipient is in his/her own bed, rather than a hospital bed, the recipient should be close enough to comfortably reach the bed. It may be necessary to position yourself on the bed with the recipient to maintain proper body alignment.

b. Moving the recipient in bed - This may be achieved by having the recipient logroll from side to side.

c. Helping the recipient move from:

i. Bed to chair and return - If this is a pivot transfer, the PCA must ensure the chair is positioned close to the bed. The recipient should have secure fitting shoes or slippers on for transfers. The PCA will position himself/herself in front of the recipient, place his/her feet against the toes of the recipient, put his/her arms under the recipients arms, place one knee in front of the recipient's knee and stand straight up, holding on to the recipient at all times.

ii. Bed to wheelchair and return - The PCA must ensure the wheelchair is in the correct position with the wheels locked in place. Make sure the wheelchair is positioned so the recipient's feet will not become entangled in the footrests. If footrests are movable, fold them up and out of the way.

iii. Bed to toilet/commode and return - The PCA should ensure the bedside commode is properly positioned beside the bed to allow the recipient to transfer with minimal exertion.

iv. Bed to tub/shower and return – The PCA should ensure the recipient is wearing secure fitting shoes or slippers. Assist the recipient to a sitting position on the side of the bed. Assist the recipient as needed to a standing position; offer stand-by assistance to the bathroom.

v. Chair to commode and return - Ensure the recipient is wearing secure fitting shoes or slippers. Assist the recipient to a standing position; provide stand-by assistance to the bathroom.

vi. Chair to tub and return - Ensure the recipient is wearing secure fitting shoes or slippers. Assist the recipient to a standing position. Provide stand-by assistance to the bathroom. Assist the recipient to disrobe and stepping into the tub.

vii. Wheelchair to tub and return - Ensure the recipient is wearing secure fitting shoes or slippers. Roll the wheelchair into the bathroom and lock the wheels. Assist the recipient to a standing position. Assist the recipient in disrobing, and stepping into the tub.

viii. Wheelchair to commode and return - Ensure the recipient is wearing secure fitting shoes or slippers. Roll the wheelchair into the bathroom and lock the wheels. Assist the recipient to a standing position. Assist the recipient in pulling down his/her underpants, and help him/her to sit safely on the commode.

d. Helping the recipient walk with a walker, crutches, or a cane walker - Ensure the recipient is wearing secure fitting shoes or slippers. Place the walker in front of the recipient, and then place the recipient's hands on the walker. Scoot the recipient to the edge of their seat and assist him/her to a standing position.

e. Crutches - Ensure the recipient is wearing secure fitting shoes or slippers. Place the crutches in front of the recipient. Have the recipient place his/her hand on the handle of the crutches and assist the recipient to a standing position.

f. Cane - Ensure the recipient is wearing secure fitting shoes or slippers. Assist the recipient in scooting to the edge of his/her seat. Place the cane in his/her strong hand.

B. Limitations on the Personal/Respite Care Aide's Activities - There are some tasks that are never to be performed by the PCA. These tasks include, but are not limited to, the following;

1. A PCA may not perform a skilled nursing task, such as changing a catheter, giving an injection, changing a sterile dressing, performing any type of tube feeding, suctioning, or cutting finger and toe nails.
2. A PCA may not provide care for other persons residing in the same home. The PCA is only to provide services to the Medicaid recipient(s).
3. The PCA must understand there are limitations to the activities that are allowed within the area of his/her expertise. If the PCA does not follow these guidelines, he/she risks causing injury to the recipient.

C. Techniques used by Personal/Respite Care Aides - The instructor is to provide a demonstration for each procedure and then have each student demonstrate the procedure.

The PCA must observe Universal Precautions at all times. Washing hands before and after each procedure is necessary, and if possible, wash hands during the procedure. Whenever there is a possibility of coming into contact with blood or bodily fluids, you must wear gloves. The PCA should remove the gloves in the correct manner (A demonstration should be given by the instructor) to prevent contamination, and wash his/her hands immediately with soap and water. The most effective way to prevent the spread of infection is by washing your hands.

1. Assisting the recipient with eating – Before feeding the recipient, ensure toileting needs are met, and all equipment used for personal care activities is removed from view. Make sure the recipient is in a safe and comfortable position to eat. Explain the procedure to the recipient.

a. Sit at or below the recipient's eye level, if possible.

b. Check the food temperature before feeding.[11]

c. Tell the recipient what the meal consists of.[11]

d. Recipient may be able to eat with his/her fingers.[11]

a. Offer liquids at intervals.[11]

b. Make pleasant conversation while feeding.[11]

c. Avoid rushing the recipient.[11]

d. Be emotionally sensitive to the recipient's needs.[11]

2. Assisting the recipient with dressing – Before dressing the recipient, ask what he/she would like to wear. Prepare all needed articles and have them within reach. Ensure the recipient is in a safe and comfortable position. Explain the procedure to the recipient before dressing him/her so that the recipient knows what you are going to do.

   a. Provide privacy and avoid exposing the recipient.[12]

   b. Wear gloves and apply principles of universal precautions if you anticipate contact with blood, body fluids (except sweat), secretions, excretions, mucous membranes, or non-intact skin.[12]

   c. Check the plan of care for special instructions and use of adaptive equipment.[12]

   d. Encourage the recipient to do as much self care as possible.[12]

   e. Clothing should be appropriate for age, and season, and color coordinated. Do not put torn clothes on recipient.[12]

   f. If the recipient has one paralyzed or weak side, remove the clothing from the strong side first. Put clothing on the weak side first. Always support the weak or paralyzed extremity.[12]

   g. It is easier to dress recipients who can assist if they are standing or sitting.[12]

   h. It is easier to dress a dependent recipient in bed.[12]

   i. Recipients who are dressed in street clothes should wear proper undergarments.[12]

   j. When dressing a recipient with catheters or tubes, treat them as part of the recipient's body. Avoid pulling on them or obstructing them. Do not disconnect them. Avoid elevating the urinary catheter above the level of the bladder during the dressing procedure.[12]

   k. Gather the pant legs and sleeves before putting them on the recipient.[12]

3. Mouth care – Ensure the recipient is in a safe and comfortable position. Explain the procedure to the recipient.

a. Gather all needed equipment.

b. Encourage the recipient to do as much self care as possible.[13]

c. Allow the recipient to brush his/her own teeth. Take the recipient to the bathroom sink if possible.[13]

d. Always wear gloves when performing oral hygiene. Avoid contaminating environmental surfaces and clean supplies with your gloves.[13]

e. Observe and report any signs of irritation, sores, loose teeth, pain, swelling, or other abnormalities to the RN supervisor.[13]

f. Handle dentures carefully.[13]

g. Let the recipient remove the dentures from the mouth if able.[13]

h. Check the dentures for cracks, chips, or loose teeth.[13]

i. Store dentures in a marked denture cup. Some dentures are stored dry and others are stored wet.[13]

4. Hair care – Allow the recipient to assist with hair care, as he/she is able. Explain the procedure to the recipient.
   a. Assist the recipient with shampooing, drying, and styling the hair as needed.
   b. The PCA should not cut or perm the recipient's hair.
   c. Use caution when using any type of heated device to style or dry hair.
5. Shaving male patients – Allow the recipient to assist, as he/she is able. Gather all needed equipment, and explain the procedure to the recipient.
   a. It is preferable that an electric razor is used when shaving the recipient.
   b. The provider agency should ensure the PCA is competent to use a disposable razor with minimal injury to the recipient.
6. Bathing (tub, shower, bed) – It is important to provide privacy for the recipient. Gather all necessary equipment and explain the procedure to the recipient. If the recipient has an indwelling catheter, washing around the urethra is considered part of the bath. If the recipient has a condom catheter, the PCA should remove the catheter, cleanse the penis and apply a new condom catheter following appropriate procedure. Instruction and return demonstration should be given in this procedure.
   a. Consult the plan of care for the type of bath to be given, special information, recipient's self-care ability, routines, use of adaptive devices, recipient needs.[15]

b. Gloves are worn for part of the bathing procedure. You will have to wash your hands and change your gloves several times during the procedure to maintain universal precautions.[15]

c. If you have open cuts or sores on your hands, you will have to wear gloves for the entire bathing process.[15]

d. Moving the recipient to the side of the bed near you may be helpful.[15]

e. Be sure the room is warm and comfortable.[15]

f. Keep the recipient's body covered with a towel or blanket for modesty and warmth. Expose only one part of the body at a time.[15]

g. Change the water if it cools off or becomes soapy or dirty.[15]

h. Soap can be irritating or drying to the skin. Be sure it is rinsed off.[15]

7. Beds (making with and without the recipient in the bed) – Begin by gathering all needed supplies, and then explain the procedure to the recipient.
   a. Have the recipient turn to one side of the bed. Ensure the rails are up, if applicable, or that the recipient is not in danger of falling.
   b. Remove the linens from one side of the bed. Roll them under the recipient's back.
   c. Apply the clean linens to the same side, and roll them under the dirty linens.
   d. Assist the recipient to turn to the other side. Again, ensure the recipient is safe.
   e. Pull the dirty linens out from under the recipient's back, pull the clean linens out, and straighten the linens out as needed.
8. Elimination – Depending on the physical abilities of the recipient this function may require the use of a bedpan, bedside commode, or going to the bathroom. Always ensure privacy for the recipient. Help the recipient wash his/her hands after he/she is finished.
   a. Bedpan
      i. If the recipient uses the bedpan, have the recipient roll over to one side. Apply a minimal amount of powder to the bedpan, which will prevent the recipient's skin from sticking to the bedpan. Place the bedpan against the recipient's buttocks and hold it in place while assisting the recipient to turn over on to the bedpan.
      ii. When the recipient is finished using the bedpan, have the recipient turn over on their side again, while holding on to the bedpan to prevent spillage.

iii. If the recipient is able to wipe himself/herself, give some toilet tissue to do so. If the recipient is unable to wipe himself/herself off, put your gloves on and wipe the recipient as needed. If necessary, use a warm washcloth and mild soap.

iv. Ensure that the recipient is safe and comfortable, then remove the bedpan and clean it thoroughly.

b. Urinal

i. If the male recipient needs to use the urinal, the PCA should wash his/her hands first, and then put gloves on.

ii. Explain the procedure to the recipient.

iii. Provide privacy for the recipient

iv. If he is able to properly place it, hand the urinal to the recipient. If the recipient requires assistance with the urinal, place it between his legs, and place his penis inside of the urinal.

v. Provide him some privacy, and return in a minute or two to see if he has finished.

vi. Assist the recipient with cleaning himself off as needed.

vii. Record the amount in the urinal if the output is being tracked.

viii. Report to the RN supervisor any complaints of burning, itching, urgency, or hesitancy by the recipient.

c. Bedside commode

i. Always ensure privacy for the recipient.

ii. Assist the recipient to sit on the side of the bed to get his/her bearings and balance.

iii. Place secure fitting slippers or shoes on his/her feet.

iv. Assist to a standing position and transfer to the bedside commode.

v. When the recipient has finished, help the recipient to wipe himself/herself off.

vi. Remove the container from the bedside commode and clean it thoroughly.

d. Toilet

i. Ensure privacy for the recipient.

ii. Help the recipient put secure fitting shoes or slippers on.

iii. Assist the recipient to sit on the edge of the bed to get their bearings and balance.

iv. Assist the recipient to a standing position, and ambulate to the bathroom.

v. When the recipient has finished, help him/her wipe off.

vi. Assist the recipient with washing his/her hands.

e. Back rub - the recipient should be lying on his/her side in a safe and comfortable position. Wash your hands, and explain the procedure to the recipient.

i. Apply lotion to your hands and rub your hands together to warm the lotion.

ii. Apply the lotion to the recipient's back, rubbing a long circular motion.

iii. Observe the back and hip areas for any signs of redness or breakdown. Report any changes to the RN.

D. Goals of Personal Care

1. Promote self-care and independence - Allow the recipient to perform as much of his/her care as possible.
2. Assure safety and comfort - Always make sure the recipient is safe and not at risk of injury.
3. Maintain dignity and self-respect - Provide privacy during all procedures.
4. Maintain stability.

E. Prevention of Skin Breakdown - The recipient is dependent on the PCA to either assist with activities of daily living or perform the tasks for the recipient.

1. The tasks are important for several reasons:

a. It provides the aide an opportunity to inspect the recipient's skin. The PCA should ensure the recipient has no red marks, bruising, bedsores, or skin tears that need to be reported. If there are skin problems, the PCA needs to communicate the problem immediately to the RN supervisor.

b. It promotes interaction and conversation with the recipient

c. It stimulates circulation, and helps prevent skin breakdown

d. It may stimulate nutrition and hydration

e. It promotes range of motion and may help to prevent contractions.

2. The PCA should monitor all bony prominences, because they may easily break down and result in a decubitus or bedsore. Other areas are also susceptible to skin breakdown as well and must be monitored during care.
3. The most effective way to prevent skin breakdown is to change the recipient's position a minimum of every two hours. Any part of the body that touches the mattress is at risk of breakdown. These parts may include the following:
    a. Hips
    b. Heels
    c. Elbows
    d. Buttocks
    e. Ears
    f. Ankles
    g. Knees
    h. Head
4. Symptoms of skin breakdown, decubitus/bedsores:
    a. Redness
    b. Blisters
    c. Itching
    d. Warm to touch
    e. Dark discoloration

F. Vital Signs - The measurement of temperature, pulse, respiration, and blood pressure, which indicates functioning of body systems and numerous types of problems. The PCA should wash his/her hands before and after this procedure. The PCA should wear gloves when assessing the recipient's temperature orally and rectally. The normal temperature is 98.6. (The instructor should demonstrate these techniques and receive a proper return demonstration from each PCA).

1. Temperature – This is measuring the amount of heat generated by the body. The normal temperature is 98.6. There are four ways to measure the temperature.
    a. Oral (O) – A thermometer is placed under the tongue.
        i. The PCA must ensure the recipient will not bite down on the glass thermometer while it is in the recipient's mouth.

ii. Make sure that the recipient has not eaten or drank any food or liquid in the past five minutes, hot or cold. The liquids may give an incorrect reading of the body temperature.

iii. The thermometer, which is normally glass, should be held at the end and briskly shaken with a snap of the wrist to ensure the mercury is below the normal temperature of 98.6. It is preferable that the temperature be 96 degrees or below before placing the thermometer in the recipient's mouth.

iv. The bulb end of the thermometer is to be placed under the tongue of the recipient and left for at least three minutes.

v. Remove the thermometer and hold it horizontally to read the temperature.

vi. Temperatures over 100 degrees should be documented and reported to the RN supervisor.

vii. Remove and discard the plastic sheath if used and clean the thermometer with a disinfectant such as alcohol.

b. Rectal (R) - A thermometer is placed in the anus;

i. The temperature is taken rectally only when the adult is not safely able to hold a thermometer in his/her mouth.

ii. Hold the thermometer by the end and briskly shake with a snap of the wrist, to 96 degrees or below.

iii. Apply a plastic sheath, if available, and a small amount of lubricant to the bulb end, such as K-Y Jelly or Vaseline, before inserting in the rectum.

iv. The thermometer should stay in place at least three minutes.

v. Remove the thermometer and hold it horizontally to read.

vi. Report temperature over 100 degrees to the RN supervisor.

vii. Remove and discard the plastic sheath if used and clean the thermometer with a disinfectant such as alcohol

c. Axillary (AX) - A thermometer is placed in the armpit. This is the least reliable place to check the body temperature. This is taken when the recipient is unable to safely hold a thermometer in the mouth and using a rectal thermometer is not possible.

i. Hold the thermometer by the end and briskly shake it with a snap of the wrist to ensure the temperature is down to 96 degrees before placing it under the recipient's arm.

ii. Place the thermometer under the recipient's arm and hold it in place for a minimum of three minutes.

iii. Remove the thermometer and hold it horizontally to read.

iv. Report a temperature over 100 degrees to the RN supervisor.

v. Clean the thermometer with a disinfectant such as alcohol.

d. Tympanic - the thermometer is placed in the ear. These are generally used in doctor offices or hospitals, however it can be found in the home. These are electronic devices and work rapidly and effectively.

i. Make sure the thermometer is turned on, if applicable.

ii. Place a plastic sheath over the con shaped end.

iii. Place the thermometer into the ear canal.

iv. Within a second or two the device will beep and the temperature will be ready to read.

2. Pulse (P) – This is counting the number of times the heart beats in one minute. This procedure requires a watch with a second hand. There are two ways to check the recipient's heart rate or pulse.

a. Radial pulse (RP) - The PCA should wash his/her hands before starting. The PCA places his/her first two fingers (not the thumb), on the recipient's wrist, straight down from the thumb. The normal pulse range is 60-80 beats per minute.

i. The PCA should hold her fingers here and count how many times the heart beat or pulse is felt for a full 60 seconds.

ii. The PCA should note if the pulse is regular or irregular.

iii. The pulse should be reported to the RN supervisor if it is below 60 times in one minute.

b. Apical pulse (AP) - A stethoscope is placed on the recipient's chest, over the heart area. The normal pulse range is 60-80 beats per minute.

i. The PCA should count the heartbeat for a full 60 seconds.

ii. The PCA should note if the pulse is regular or irregular.

iii. The pulse should be reported to the RN supervisor if it is below 60.

3. Respirations (R) – This is the measurement of how many breaths the recipient is taking per minute. A breath is considered one inhalation and one expiration. The normal respiratory rate is 18-20 per minute.

a. The PCA should try not to stare at the recipient's chest while counting respirations; this may make the recipient inadvertently change their breathing pattern.

b. Generally, respirations can be counted after taking the pulse. Just continue to hold the recipient's wrist as if you were still counting the pulse, but watch the breathing pattern. This should be counted for a full minute.

c. The PCA should document the rate and note if there were periods when no breath was taken (apnea).

4. Blood Pressure (BP)-Measuring the pressure of the heart contracting and at rest. The normal blood pressure range is 120-140/70-80. This requires a blood pressure cuff and a stethoscope. A demonstration and a return demonstration by each student are required.

a. The PCA must ensure the blood pressure cuff is fully deflated before applying it to the recipient's arm, just above the recipient's elbow.

b. Place the stethoscope in the bend of the elbow. Make sure the valve is closed, and pump the cuff up to 160. If the recipient complains of pain during this procedure, you have pumped the cuff up too tight.

c. Slowly release the valve and listen for the very first beat while watching the gauge. This is the top number, or systolic. This measures the heart contracting.

d. Continue listening for the last beat, while watching the gauge. This is the bottom number, or diastolic. This measures the heart at rest.

e. Record the BP and report it to the RN supervisor if it is under 110-(systolic)/60-(diastolic), or over 140/90.

f. Note if the recipient is experiencing any adverse symptoms, such as a headache or nosebleed, which may indicate high blood pressure. Also note if the recipient is feeling dizzy or lightheaded, which may indicate a low blood pressure.

IV. Home Management

The PCA has many responsibilities that go beyond the health care of the recipient. These responsibilities include the home, environment, and safety. DMAS recommends each agency request the local police department to give a class or an in-service in personal safety for the class. It is also recommended that each agency request the local fire department give a demonstration of fire safety in the home. The fire demonstration should include how and when to remove a bed-bound recipient from a burning home, how to properly use a fire extinguisher, and when to call for help.

A. Care of the Home and Personal Belongings

1. Importance of maintaining a clean environment - To promote health and prevent the spread of disease or possible injury.

2. Housekeeping duties are for the living areas of the recipient. The PCA is not a Housekeeper for other family members in the home.
    a. Scheduling of tasks - The RN supervisor will discuss with the recipient and caregiver how often the housekeeping tasks need to be performed. This information will be included in the plan of care. If the recipient requests the task more often than authorized, permission should be obtained from the RN supervisor.
    b. Types of cleaning and laundry supplies - Each recipient has his/her own preference for what types of cleaning supplies are to be used. All supplies are to be furnished by the recipient. The PCA should ensure proper ventilation when using cleaning supplies near the recipient.
    c. Organization of supplies and equipment - The PCA should gather all supplies and equipment prior to beginning the cleaning of any one room or area. This will promote efficiency.
    d. Use of proper body mechanics - The PCA should ensure the use of proper body mechanics when performing any housekeeping task to prevent injury.
3. Routine care and use of:
    a. Cleaning equipment - All equipment should be cleaned after the completion of the task.
    b. Laundry equipment - The PCA should make sure he/she knows how to use the washer and dryer. The PCA should also know what detergent /fabric softener the recipient uses. Any spillage of detergent or fabric softener should be immediately wiped up.
    c. Kitchen equipment - The PCA should make sure he/she knows how to use the stove, oven, microwave, and dishwasher. Any spillage of food should be immediately cleaned up.
4. Emergencies related to heating equipment - The PCA should notify the caregiver immediately if there is no heat. If there is a financial problem that hinders the recipient from purchasing fuel for heat, the RN supervisor may contact a community resource for assistance.
    a. Water supply - The PCA should notify the caregiver and the RN supervisor if the water has been turned off. Water is essential for bathing, cooking, and proper functioning of the toilet.
    b. Electricity - The PCA should notify the caregiver and the RN supervisor if the electricity is turned off. There may be community resources able to assist the recipient.
5. Care of furniture - The PCA should dust the furniture or clean the glass on the furniture in the recipient's immediate area, as needed.

6. Repair of clothing and linen - The primary caregiver should be notified when clothing or linen requires repairs. The PCA is not to repair these items.
7. Pest Control - If pests are observed, it should be reported to the RN supervisor who will contact the primary caregiver or will take whatever action is appropriate.
8. Care of the recipient's environment - The Plan of Care will list what housekeeping duties are required. The PCA is required to clean up whatever was used to prepare the recipient a meal. The kitchen floor should be swept as needed, and damp mopped at least once a week. The recipient's linen should be changed as indicated on the plan of care, and the bed should be made daily. The recipient's bedroom should be dusted and vacuumed at least once a week.

V. Safety and Accident Prevention in the Home

A. Common Types of Accidents

1. Falls
2. Burns
3. Medication errors

B. Accident Prevention

1. Wiping up all spills immediately can prevent falls. Any area rugs should be removed to prevent the recipient's foot from catching on the rug. The recipient should never be left alone to get in or out of the tub by himself/herself.
2. Burns are best prevented by the PCA assisting with all cooking unless the recipient is independent in this activity. The PCA should make sure the bath water is not too hot to the touch.
3. Using a pre-filled medication box can prevent medication errors. This allows a qualified person to set up the recipient's medications for a week. The PCA can assist the recipient to open the box, or remind the recipient it is time to take the medication, and furnish a liquid to the recipient. If a pre-filled medication box is not used, the PCA should remind the recipient when it is time to take a medication, and document in the Aide Record that the recipient took medications as directed.

C. Typical Hazards in the Home

1. Bathroom (i.e., slippery floor, hot water, towels or clothes in the floor)
2. Kitchen (i.e., stove, hot water, sharp utensils)
3. Stairway (i.e., no hand rail, carpet on stairs, slippery stairs)

4. General (i.e., area rugs, extension cords, space heaters)

D. Ways to Safety-Proof the Home:

1. Remove all area rugs
2. Assist the recipient with all activities as needed in the kitchen
3. Assist the recipient in the bathroom
4. Remove all clothes and towels from the floor
5. Ensure extension cords are not running across the path the recipient would walk
6. Ensure there is a hand rail on the stairs and it is strongly attached to the wall
7. Make sure the recipient is always wearing secure fitting shoes or slippers when ambulating
8. Ensure there is adequate ventilation when a space heater is in use
9. Suggest that the caregiver turn the temperature down on the hot water heater, if needed and if recipient is at risk of a burn.

E. Policies and Procedures Regarding Accidents or Injuries

1. Limitations of the PCA.
    a. The PCA should never move a recipient after a fall until the recipient has been evaluated. The recipient may break a hip or another bone from a fall, which could lead to more damage if the recipient is moved.
    b. The PCA should never clean a wound with anything other than soap and water.
    c. If the PCA needs to apply a bandage to an injury, it should not include any salve, cream, ointment, or medication.
    d. The PCA should call the RN supervisor immediately about any accidents or injuries, and 911 if needed.
2. Techniques of simple first aid
    a. Treatment of abrasion - The abrasion should be cleaned with a clean washcloth and mild soap and water. The RN supervisor should be notified; he/she will evaluate and call the doctor for orders if needed.
    b. Treatment of cuts and bruises - There is no treatment for bruises. However, if the recipient bumps into something and a knot starts forming, a cold compress may be applied to relieve some of the pain. The RN supervisor should be notified of the incident before the application of any type of compress. The incident should also be documented in the Aide Record. Cuts should be reported to the RN

supervisor immediately. Some cuts may require an emergency room visit for sutures. If the recipient should sustain a cut, apply direct pressure with a clean washcloth or towel. Do not remove the compress to see if the cut has stopped bleeding. A medical professional will remove it in the emergency room.

c. Treatment of first and second-degree burns - A first-degree burn will appear red. Apply cold water. Do not apply ice; ice may cause further damage. Do not apply any ointment, cream, or salve without RN supervisor instruction. A second-degree burn will blister. Apply cool water. Notify the RN supervisor of any burns immediately, and document in the Aide Record. Do not apply any salve, cream, ointment, and especially do not apply butter to the burn.

d. Poisoning - Immediately notify the RN supervisor. Do not give the recipient anything to eat or drink. There are some poisons that cause more damage if the recipient vomits. Do not induce vomiting unless specifically told to do so by the RN supervisor, a physician, 911, or the Poison Control Center.

VI. Food, Nutrition, and Meal Preparation

A. Importance of Nutrition to the Individual

1. Proper nutrition promotes health and wound healing. Research has shown that proper nutrition also alleviates some confusion in the elderly.

B. General Concept of Planning Meals

1. Nutritional value - Meals should consist of foods from the major food groups. There should be limited sweets at mealtime. Protein is an important part of nutrition in the elderly.

2. Cultural and ethnic food patterns - Different cultures and religions have limitations on what types of food are permitted. Foods should be appropriate to the recipient's culture, ethnic, and religious beliefs.

3. Individual likes and dislikes - These must be observed. The recipient should have input into the meal planning process with likes and dislikes of the recipient respected. Appropriate substitutes may be found.

4. Budgetary limitations - Most recipients are on a fixed income, and therefore are limited to what types of food they can buy. If it appears the recipient is not buying nutritious foods due to income, the RN supervisor should be notified; there might be a community resource that can assist with groceries.

C. Special Considerations of Normal Diet

1. Elderly - The recipient may be on a normal diet; most elderly persons benefit from six small meals rather than three large meals. The recipient's ability to chew food must also be considered. Food may need to be chopped or pureed to prevent choking while eating.
2. Illness - The recipient may be on a normal diet but may not be able to tolerate foods because of illness. It would be appropriate to provide the recipient with what he/she can tolerate.

D. Special Considerations in Preparation of Special Diets

1. Importance of Special diets - If the recipient is on a special diet, it must be observed as closely as possible. A special diet may be used for someone who has diabetes, kidney failure, severe burns, respiratory problems, ulcers, or circulatory problems.
2. Common types of special diets - Diabetics may be on a diet that limits foods that convert to sugars. Someone with ulcers may need a bland diet to prevent stomach discomfort. Someone with a history of blood clots may need foods that are low in vitamin K, which works against blood thinners. Recipients who have kidney failure may have frequent changes to their dietary requirements, especially if they are receiving dialysis.
3. Policy and procedure regarding the aide's activities in relation to special diets - The PCA may not decide if a recipient needs a special diet and impose such a diet. The PCA's responsibility is to be aware of the dietary requirements of the recipient and prepare food as required. If the PCA does not understand the dietary requirements, he/she should notify the RN supervisor immediately for clarification.

E. Food Purchasing and Preparation

1. Buying guides
    a. The PCA should buy brands of foods that the recipient prefers.
    b. The PCA should buy the size and quantity the recipient prefers. The PCA should not buy the largest size available just because it may be cheaper. There may be storage issues and the food may go bad before the recipient can use it all.
2. Techniques of food preparation
    a. Must be prepared with the recipient's dietary requirements in mind.
    b. Should be prepared with limited seasonings, unless specifically requested by the recipient.
    c. If there are no dietary restrictions, food should be prepared in the manner the recipient requests.

F. Food Storage and Sanitation

1. Foods should be properly stored in the refrigerator, as needed, such as milk, butter, meats that will be used in the next three days.
2. Meats and other normally refrigerated foods that will not be used in the next three days should be placed in the freezer.
3. The PCA should wash his/her hands before touching any food.
4. To thaw meats or other items from the freezer, place the items in the refrigerator until they are usable. Do not set food items out on the counter to thaw.

VII. Documentation Requirements for Medicaid Recipients

A. Aide Record – All Medicaid Aide Records (DMAS-90) are to be completed at the time the service is provided to the recipient. Do not fill them out in advance. The Department of Medical Assistance Services (DMAS) requires the following documentation on all Aide Records:

1. Recipient's name
2. The complete date for each day worked - include the month, day, and year, (example: 05/25/02).
3. Place check marks (v) for each service that was provided to the recipient. Only provide services that are checked on the recipient's Plan of Care. If you are checking a task that is not marked on the plan of care, you must document the reason it was done. If you are not checking a task marked on the plan of care, you must document why you did not do it.
4. The PCA arrival time, including a.m. or p.m.
5. The PCA departure time, including a.m. or p.m.
6. The total number of hours provided to the recipient for the day
7. Weekly comments that give a picture of the recipient's response to services provided during the week include any complaints, and any important changes. Document the recipient's appetite, complaints of pain, if they stay in bed but they are usually up, if you notice any marks on the skin while bathing, and information that might be useful to the RN supervisor.
8. The recipient or caregiver's signature
9. The signature of the PCA
10. The PCA should never use white out to cover over errors. Mark one line through the error, initial and date the change, and re-write the correct information.

B. Provider Agency Plan of Care - The RN Supervisor will make a home visit and determine how many hours a day and how many days a week of care are appropriate for the recipient.

Footnotes:

1 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 2, page 20.

2 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 2, page 22.

3 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 2, page 22.

4 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 2, page 23.

5 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 2, page 24.

6 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 2, page 24.

7 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 2, page 25.

8 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 2, page 26.

9 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 2, page 27

10 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 2, page 29.

11 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 11, page 202

12 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 10, page 190.

13 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 10, page 170.

14 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 10, page 187.

15 Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999) Chapter 10, page 174.

Bibliography

1. Barbara Acello, Nursing Assisting Essentials for Long-Term Care (Albany: Delmar, 1999)

2. The Elderly and Disabled Waiver Manual, The Department of Medical Assistance Services.

SKILLS CHECK LIST

Training Agency's Name: _____

Instructor's Name (Print): _____

Student's Name (Print): _____

[The instructor should date and sign after each task or procedure is performed by the student.]

TASK OR PROCEDURE	DATE OF SUCCESSFUL DEMONSTRATION	INSTRUCTOR'S SIGNATURE
Effective Communication		
Hand washing technique		
Making an unoccupied bed		
Making an occupied bed		
Using assistive equipment in bed		
Turning recipient side to side in bed		
Transfer non-ambulatory recipient from the bed to chair or wheel chair		
Giving a partial bath to bed confined recipient		
Giving a complete bath to bed confined recipient		
Giving tub/shower bath		
Perineal care male/female		
Skin care		
Hair care including shaving the male recipient		
Providing passive range of motion exercises		
Oral hygiene with/without dentures		
Dressing or assisting with dressing the recipient		
Assisting recipient with self administered medications		
Preparing and serving the recipient a meal		
Feeding recipient who is unable to self feed		
Cleaning/straightening recipient area and other areas used by the recipient including kitchen and bath		
Wear gloves when appropriate		
Recipient's laundry		

DEFINITIONS

Activities of daily living (ADL) - Personal care tasks such as bathing, dressing, toileting, dressing, eating, and ambulating.

Bathing - The process of washing the body or body parts, including getting to or obtaining the bathing water and/or equipment whether this is in the bed, shower or tub.

Body Mechanics - Process of using proper body alignment when moving a recipient to prevent injury to the recipient and the personal care aide.

Bowel movement - The physiological process of emptying feces from the bowel.

Complete bath - Bathing the recipient from head to toe, whether in the shower, tub, or bed.

Condom catheter - A condom type covering over the penis to collect urine through a tube into a collection bag.

Decubitus - A sore that usually develops over a bony part of the body. It is also known as a bedsore or a pressure sore.

Department of Medical Assistance Services (DMAS) – Medicaid of Virginia

Dependent - Unable to care for one's self. Someone must perform care for the recipient.

Dressing - The process of putting on, fastening, or taking off all items of clothing, braces, and artificial limbs that are worn daily by the recipient. This includes obtaining and replacing the items from a storage area in the immediate environment.

Eating/Feeding - The process of getting food by various means from the receptacle (plate, cup, bowl, glass, and bottle) into the body.

Extremity - Refers to arms or legs.

Foley Catheter - a tube in the urethra to collect urine.

Grooming - The process of brushing the recipient's teeth, cleaning dentures, combing or brushing hair, and shaving.

Housekeeping - Cleaning of the living areas used by the recipient. Such as cleaning the kitchen after preparing a meal for the recipient, making the recipient's bed, changing the linens, mopping the floor or cleaning the bathroom if the recipient uses it. This also includes washing the recipient's laundry as needed.

Nothing per oral (NPO) - Nothing by mouth includes food, drinks, and medications.

Partial bath - Bathing only parts of the recipient rather than the entire body.

Personal Care - Services provided by a Medicaid provider agency to assist the recipient with activities of daily living.

Personal Care Aide (PCA) - Someone who has taken and passed a 40 hour training program with emphasis on how to provide personal care to recipients in the home environment

Plan of Care (POC) - Those activities and services that a recipient needs. A form used by the provider agency to develop a plan for the number of hours, days of the week, and the tasks the personal care aide is to assist with.

Respite Care - A service provided to the live-in primary caregiver, to give him/her relief in the 24-hour responsibility of care.

Recipient - A person who meets the Virginia Medicaid eligibility criteria requirements and is receiving or has received medicaid services.

Supervision - A block of time specified on the plan of care to allow the PCA to be with the recipient to ensure safety. This is for a recipient who would not be capable of calling for assistance and therefore should not be left unattended.

Toileting - The process of getting to and from the toilet room for elimination of feces and urine, transferring on and off the toilet, cleaning one's self after elimination, and adjusting clothes.

Transferring - The process of moving horizontally and/or vertically between the bed, chair, wheelchair, and/or stretcher.

Universal (Standard) precautions - The technique of protecting oneself from the spread of infectious disease while providing care to the recipient and protecting the recipient from contracting a disease from the personal care provider.

Urination - The physiological process of emptying urine from the bladder.

Vital signs - blood pressure, pulse, temperature, and respirations. (BP, T, P, R)

Final Test

Match the following vocabulary words with the correct definition:

1.	Plan of care	_____	A.	Temperature, pulse, respiration, blood pressure
2.	Universal Precautions	_____	B.	Break for live-in caregiver
3.	Grooming	_____	C.	Person who is Medicaid eligible for care
4.	Recipient	_____	D.	Block of time to keep someone safe in home
5.	Activities of daily living	_____	E.	Sore that forms from immobility
6.	Toileting	_____	F.	Assistance to the recipient to keep them in their home
7.	Vital signs	_____	G.	Technique to prevent spread of infection
8.	Supervision	_____	H.	Schedule of tasks, hours per day and days per week
9.	Transferring	_____	I.	Area that has little subcutaneous tissue
10.	Personal Care	_____	J.	Bathe, dress, eat, groom, transfer, ambulate
11.	Respite	_____	K.	Brushing teeth, combing hair, shaving
12.	Decubitus	_____	L.	The process of elimination of waste
13.	Bony Prominence	_____	M.	Physically moving someone from one place

A. Circle the best answer for each question

14. If my recipient yells at me I should:

a. Yell back
b. Tell him to stop
c. Leave him alone a few minutes
d. Call the Police

15. If my recipient wants me to give the dog a bath I should:

a. Tell him, “get a grip.”
b. I should give the dog a bath
c. I should say no, but explain why
d. Take the dog home and bathe him

16. The recipient's daughter wants me to drive the recipient to the doctor, I should:

    a. Drive him carefully to the doctor
    b. Call him a cab
    c. Say no, and offer to call the RN and get permission to escort the recipient if the daughter drives.
    d. All of the above

17. List five different bony prominence:

    1.
    2.
    3.
    4.
    5.

18. What are some of the symptoms of a skin breakdown?

    a. Itching
    b. Blisters
    c. Redness
    d. All of the above

19. When transferring a recipient the best thing to do is:

    a. Make sure they are barefoot
    b. Make sure they have their socks on
    c. Make sure they have shoes or slippers on
    d. None of the above

20. List 4 physical aspects of aging

    1.
    2.
    3.
    4.

B. True or False

T F 21. DMAS does not require a signature from the recipient and/or the aide on the Aide Record (DMAS-90).

T F 22. When providing Personal Care services to a recipient, the PCA must do whatever the recipient asks.

T F 23. It is all right to stay with the recipient beyond my designated time without notifying the RN Supervisor.

T F 24. The RN supervisor should be notified when there is a problem with the recipient.

T F 25. The plan of care tells the PCA how long to provide care to the recipient and what services to provide.

26. List 5 activities of daily living:
    a.
    b.
    c.
    d.
    e.

27. What is the purpose of Respite?
    a. To help the recipient a little longer
    b. To help the RN supervisor
    c. To give relief to the primary live-in caregiver
    d. To give the PCA time to do all of the tasks on the plan of care

28. Name 5 physical changes the elderly experience:
    a.
    b.
    c.
    d.
    e.

29. Give the normal values for each:
    a. Temperature -
    b. Pulse -
    c. Respiration -
    d. Blood Pressure -

30. What is the best way to prevent the spread of infection?

31. How can you prevent decubitus?

32. What are body mechanics?

33. This is a scenario of you providing care to a recipient, John Smith, in the home. You must complete the attached Aide Record correctly. You arrive at John Smith's home at 8 am. You assist Mr. Smith with a bath, brush his teeth, comb his hair, and help him get dressed. Mr. Smith is wheelchair bound, so you help him get from the bed to his wheelchair. You take Mr. Smith into the kitchen, where you prepare his breakfast, and clean the kitchen afterwards. While Mr. Smith is eating, you go back into the bedroom and make up his bed, and clean his bathroom. Mr. Smith has now finished eating, so you wash his dishes, and assist him with his medications. You do a load of laundry for Mr. Smith. Mr. Smith needs to go to the bathroom, so you help him get into the bathroom and pull his pants down for him. Your assigned time to leave Mr. Smith is 12 noon, so you prepare some lunch for Mr. Smith and make sure he is safe. Mr. Smith ate well today. He complained of pain in his left foot, but there were no marks noted when you bathed him. Complete the Aide Record for the whole week using this information. You begin on Monday, June 1, 2002 and will work through Friday, June 5, 2002. You will repeat these duties each day.

NOTE: ATTACH A COPY OF A BLANK PROVIDER AIDE RECORD (Personal/Respite Care Record)

Instructions for test.

1. Each question is worth 2 3/4 points each except for question # 33, which is worth 12 points.
2. The minimum passing score for the test is 70%
3. In addition to the written test, the student must be checked off and have the instructor signature on all items listed on the skills checklist.

Provider Agency, Inc.

Personal Care Aide Training Program

Certificate of Completion

This Certifies that

_____

Has Successfully Completed the 40-hour Aide Training Program on this Date

_____

This Person May Provide Medicaid Personal Care Services in the Commonwealth of Virginia.

_____	_____
Instructor/Title	Administrator
_____	_____
Date	Provider Agency / Provider Number

First Health
Services Corporation

MAILING SUSPENSION REQUEST
SERVICE CENTER AUTHORIZATION
SIGNATURE WAIVER
PHARMACY POINT-OF-SALE

Please review and check the blocks which pertain to you:

☐ **MAILING SUSPENSION REQUEST:**

I do not wish to receive Medicaid memos, forms, or manual updates under the Medicaid provider number given below.

☐ **COMPUTER GENERATED CLAIMS:**

I certify that I have authorized the following service center to submit computer-generated invoices (by modem, diskette or tape) to Virginia Medicaid:

_____
(Service Center Preparing Invoices)

Service center code: _____ **Magnetic Tape RA:** YES NO (Circle One)

Prior service center code: _____

☐ **SIGNATURE WAIVER:**

I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer generated, or stamped signature.

☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**

I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-5105